- Genitourinary (Urinary tract Infections, Urethritis, Balanitis, Candidiasis, Mastitis, Foreign Body).
- Sexual & Reproductive Health (Mastitis, Sexually Transmitted Infections, Emergency Contraception, Minor 1st Trimester Vomiting).
- Musculoskeletal (Sprains/Strains, Uncomplicated Fractures, Uncomplicated dislocations, Pulled elbow, Contusions, Costochondritis, Plantar Fasciitis, Epicondylitis, Bursitis, Acute Gout, Torticollis, Uncomplicated Back Pain).
- Immunology and Toxicology (Allergic Reaction, Minor Insect Bites and Marine Stings).
- Neurology (Migraine with Previous History).
- Skin (Wound Care, Minor Thermal and Chemical Burns, Lacerations, Bites, Acute Minor Wounds, Wound Infections, Cellulitis Boils/Carbuncles, Dermatitis, Shingles, Varicella,
- Wound dressing, Plaster application, Immunisation

Appropriate referral will be made for conditions requiring ongoing investigation, treatment, contact tracing and follow-up (Example Sexually Transmitted Infections).

Diagnostic Investigations:

The NP may order the following studies to assist in the diagnosis and/or management of acute, episodic illnesses

Pathology

Full Blood Count (FBC)

Urea, Electrolytes and Creatinine (UEC)

Liver Function Test (LFT)

Erythrocyte Sedimentation Rate (ESR)

C Reactive Protein (CRP)

Calcium, Phosphate, Magnesium (CaPo4Mg)

Coagulation Studies (COAGS) consisting of: Activated Partial Thromboplastin Time (aPTT); Prothrombin Time (PT) including International Normalized Ratio (INR); Fibrinogen; D-Dimer

Beta HCG Pregnancy Assay

Thyroid Function Tests

Amylase

Anion Gap (AG) – Calculated

Bicarbonate (HCO3-)

Bilirubin Direct

Bilirubin Total

Calcium Ionised (iCa)

Chloride (Cl)

Glucose (BGL) fasting or random

Ferritin

Ketones

Lactate

Lipase

Microbiology

Direct microscopy, culture and antibiotic sensitivity of specimens including:-

Blood,
Faeces including ovae, parasites and cysts
Sputum,
Urine,
Nasal, oropharangeal, nasopharyngeal aspirate
Wound swabs (deep and superficial).
Eye and/or ear swabs
Cervical, vaginal and urethral
Fungal scrapings

Immunology and Immunodiagnostic

C Reactive Protein

Epstein Barr Virus

Pertussis

Rubella

Hepatitis A, B C

Varicella

Syphillis

Chlamydia

Gonorrhoea

Faecal Occult Blood

Medical Imaging

Plain Axial Skeleton

Plain Chest

Abdominal X-Ray

Diagnostic imaging that is interpreted prior to formal reporting will be reviewed by the Nurse Practitioner, with abnormal results prompting review per appropriate patient care.

Other investigations may be ordered upon discussion with a collaborating medical officer, general practitioner, or senior registrar.

Health Promotion/ Illness Prevention Strategies

This may include, but is not limited to:

- Immunisation
- Health literacy support materials
- Provision of consumer medicines information
- Lifestyle modification (diet and physical activity)
- Weight management
- Smoking cessation
- Safe sex
- Stress management
- Alcohol and other drug moderation
- Wound care
- Physiotherapy
- Hazard assessment
- Personal protective equipment

Non-Pharmacological Management Approaches

This may include, but is not limited to:

- Massage
- Pressure Area Management
- Diversional Therapy
- Pelvic Floor Exercises
- Self care strategies
- Rest
- Elevation
- Dressings, bandaging, compression, splint and sling
- Minor surgical procedures and suturing
- Condoms
- Crutches
- Hydration
- Skin care
- Hygiene
- Bowel management
- Thermoregulatory (ice/heat packs)
- Earwax removal

Pharmacological Management

Pharmacological management will include medications and oral rehydration preparations relevant to the management of injuries and illnesses appropriate for acute, episodic care. Examples of conditions requiring pharmacologic treatment in the context of acute, episodic care are:

- Ear, Eye, Nose, Sinus & Throat Infections
- Common Cold/ Influenza
- Upper & Lower Respiratory Tract Infections
- Acute Asthma & Chronic Obstructive Airway Disease exacerbations
- Gastrointestinal Infections
- Nausea/Vomiting
- Urinary & Sexual Transmitted Infections
- Emergency Contraception
- Constipation/Diarrhoea
- Fever
- Pain
- Skin & Wound Infections
- Allergy Symptoms
- Sprains and Strains
- Minor Fractures
- Minor Lacerations, Abrasions & Puncture Wounds
- Minor Burns
- Animal & Insect Bites
- Acute Gout
- Shingles
- Digital Nerve Blocks

Medication Formulary

The WiC NP is authorised to dispense/ prescribe to patients those medications contained in the formulary within the Nurse Practitioner Clinical Practice Guidelines.

It is the NP's responsibility to use this formulary in conjunction with the most recent Australian Medicines Handbook & Therapeutic Guidelines to identify the currently accepted correct dosage and duration of therapy, contraindications, precautions and adverse effects.

This formulary provides for the poisons and restricted substances that may be possessed, used, supplied or prescribed by Nurse Practitioners under section 17A of the Poisons and Therapeutic Goods Act 1966 and forms part of approved Nurse Practitioner guidelines.

Medication Formulary

Drug	Route	Therapeutic Class	Poisons Schedule
Aciclovir	PO, Top	Antiviral	S4
Adrenaline	Neb, IV, IM, SC	Adrenergic stimulants/vasopressor	S3
Amethocaine	Top	Local anaesthetic	S2
Amoxycillin	PO	Antibioitic	S4
Amoxycillin Clavulanic acid	PO	Antibiotic	S4
Anorectal products	PR	Laxative, analgesics	Unscheduled
Atropine	IV	Cholinergic/anticholinergic agent	S4
Aspirin	PO	Anti-inflammatory	Unscheduled
Aspirin Codeine	PO	Anti-inflammatory/Analgesia	S2
Azithromycin	PO	Antibiotic	S4
Beclomethasone	INH	Steroid	S2
Betamethasone Acetate	INH	Steroid	S4
Betamethasone Valerate	Top	Steroid	S4
Budesonide	INH	Steroid	S4

Drug	Route	Therapeutic Class	Poisons Schedule
Bupivacaine	SC	Local anaesthetic	S4
Cefaclor	PO	Antibiotic	S4
Cefuroxime	PO	Antibiotic	S4
Celocoxib	PO	Antiinflammatory	S4
Cephalexin	PO	Antibiotic	S4
Chloramphenicol	Top	Antibiotic	S4
Ciprofloxacin	PO	Antibiotic	S4
Clarithromycin	PO	Macrolide	S4
Clindamycin	PO	Macrolide	S4
Clotrimazole	Top, PO	Antifungal	S2
Colchicine	PO	Musculo skeletal	S4
Dexamethasone	PO, IM, IV	Steroid	S4
Dextrose 50%	IV	Dextrose	Unscheduled
Diazepam	PO	Anti anxiety agents/ Anticonvulsant	S4
Diclofenac	PO	Antiinflammatory	S4
Dicloxacillin	PO	Antibiotic	S4
Diphenylhydramine	PO	Antihistamine	S2
Docusate	PO	Laxative	Unscheduled
Docusate Senna	PO	Laxative	Unscheduled
Domperidone	PO	Antiemetic	S4
Doxycycline	PO	Antibiotic	S4
Ear Preparations	Top	Steroid, Antibiotic	S4
Electrolyte Solutions	PO	Electrolytes	S4
Erythromycin	PO	Antibiotic	S4

Drug	Route	Therapeutic Class	Poisons Schedule
Esomeprazole, Lansoprazole, Omeprazole, Pantoprazole, Rabeprazole	PO	Proton Pump Inhibitor	S4
Famciclovir	PO	Antiviral	S4
Flucloxacillin	PO	Antibiotic	S4
Fluconazole	PO	Antifungal	S4
Frusemide	PO	Diuretic	S4
Flourescein	Top	Ophthalmic agent	Unscheduled
Fluticasone Salmeterol	INH	Preventative aerosol	S4
Gastrogel, Mylanta, Gaviscon	PO	Antacid	S2
Glucagon	SC, IM	Anti Hypoglycaemic	S4
Glucocorticosteroid	INH	Steroid	S4
Glucose	PO	Anti hypoglycaemic	Unscheduled
Homatropine	Top	Mydriatic	S4
Hydrocortisone	Top	Steroid	S4
Hyoscine Butylbromide	PO	Antispasmotic	S4
Hypromellose Dextran, Antazoline/ Naphazoline, Ketotifen, Acular, Diclofenac sodium	Top	Ocular lubricant, anti histamine, NSAID, Analgesia	Unscheduled, S4
Ibuprofen	PO	Anti-inflammatory	S2
Ibuprofen / Codeine	PO	Anti Inflammaory	S3
Indomethacin	PO, PR	Anti-inflammatory	S4
Ipratropium bromide	INH	Bronchodilator aerosols & inhalation	S4

Drug	Route	Therapeutic Class	Poisons Schedule
Ivermectin	PO	Anthelminitics	S4
Kenacomb	Top	Steroid	S4
Ketorolac	IM, PO	Anti-inflammatory	S4
Levonorgestrel	PO	Contraceptive	S3
Lignocaine	SC	Local anaesthetic	S2
Lignocaine adrenaline	SC	Local anaesthetic	S3
Lignocaine	Top	Anaesthetic	S4
Lignocaine chlorhexadine	Top	Anaesthetic gel	S4
Xylocaine viscous	PO, Top	Anaesthetic	S3,
Lignocaine prilocaine	Top	Anaesthetic cream	S4
Loperamide	PO	Antidiarrhoeals	S2
Loratidine, desloratadine, Cetirizine, Fexofenadine, Dexchlorpheniramine, Trimeprazine	PO	Antihistamine	S2, S3
Macrogol/ Movicol	PO	Laxative	Unscheduled
Mometasone	Top	Steroid	S4
Metoclopramide	IM, PO, IV	Antiemetic	S3
Midazolam	PO,IN	Sedative/Hypnotics	S4
Miconazole	Top	Antifungal	S2
Morphine	IM, SC	Narcotic analgesic	S8
Mupirocin	Top	Antiviral	S4
Naloxone	IM, IV	Opioid Antagonist	S4
Naproxen	PO	Antiinflammatory	S4
Norfloxacin	PO	Antibiotic	S4

Drug	Route	Therapeutic Class	Poisons Schedule
Omeprazole	PO	Proton Pump Inhibitor	S4
Ondansetron	SL, PO	Antiemetic	S4
Osteltamivir	PO	Antiviral	S4
Oxygen	INH		
Oxycodone	PO	Narcotic analgesic	S8
Paracetamol	PO, PR	Analgesic	S2
Paracetamol Codeine	PO	Analgesic	S2-S4
Phenoxymethylpenicillin	PO	Antibiotic	S4
Pholcodine	PO	Cough Suppressant	S3
Permethrin	Top	Scabies treatment	unscheduled
Prednisolone	PO	Steroid	S4
Prilocaine	Top	Topical Anaesthetic	S4
Prochlorperazine	PO	Antiemetic	S4
Promethazine Hydrochloride	PO	Antihistamine	S4
Pseudoephedrine	PO	Decongestant	S3
Pyrantel	PO	Anthelminitics	S2
Ranitidine	PO	H_2 antagonist	S4
Roxithromycin	PO	Macrolide	S4
Salbutamol	INH	Bronchospasm relaxants	S4
Silver nitrate	Top	Cauterizing agent	Unscheduled
Silver Sulphadiazine	Top	Antibacterial burn treatment	S4
Sodium Citrotartrate	PO	Urinary Alkaliniser	Unscheduled
Sodium Phosphate	PR	Laxative	Unscheduled
Sodium Picosulfate	PO	Laxative	S3
			Poisons

Drug	Route	Therapeutic Class	Schedule
Terbinafine	PO	Antifungal	S4
Trimethoprim	PO	Antibiotic	S4
Sulfamethoxazole, trimethoprim	PO	Antibiotic	S4
Immunoglobulin (Zoster, Anti D, NHIG, other in response to ACT public Health Advice.	IM, SC	Immunoglobulin	S4
Vaccines (ADt, Boostrix, MMR, other in response to ACT public Health Advice.	IM	Vaccine	S4
Valaciclovir	PO	Antiviral	S4

Intravenous Fluids
Crystalloid - 0.9% Normal Saline, 4% Dextrose 1/5 Normal Saline, Hartmann's Solution, 5% Dextrose

A medication not on this list may be considered on the advice or order of a senior medical officer.

Medications and methods of administration used in advanced life support may be given by the Nurse Practitioner in life threatening situations. An examples is adrenaline via intraosseous or endotracheal tube administration

Other medications that are not listed above, that are available "over the counter", such as schedule 2 or 3 medications may be recommended by the Nurse Practitioner.

Follow Up Care

This would include, but is not limited to:

- Monitor test results and communicate to patient and relevant/collaborating healthcare professionals (Example GP, Emergency Department, Allied Health). Diagnostic tests that are ordered by the NP are to be followed up and actioned by that NP in a safe and timely basis, unless arranged previously with another NP. This will require After-Hours access to the ACT Health Network.
- Evaluate therapeutic response
- Management of abnormal results within scope of practice (Example wound culture)
- Monitor Progress

Plan for dissemination of Clinical Practice Guidelines

The WiC NP Clinical Practice Guidelines will be posted on The ACT Government Health- Directorate website.

- Copy held at the Office of the Chief Nurse, ACT Health
- Copy held at the WiC, The Canberra Hospital
- Copy lodged with the Australian College of Nurse Practitioners

Plan for Implementation of Clinical Practice Guidelines

The NP will implement the full scope of practice once approval has been gained.

Plan for review and revision of Clinical Practice Guideline.

Update and review three years from date of guideline approval and third yearly thereafter. Update and review may occur more frequently as per the discretion of the NP (with significant changes in evidenced based practice or changes in practice setting/ collaborative agreement).

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Drug	Route	Therapeutic Class	Poisons Schedule
Omeprazole	PO	Proton Pump Inhibitor	S4
Ondansetron	SL, PO	Antiemetic	S4
Osteltamivir	PO	Antiviral	S4
Oxygen	INH		
Oxycodone	PO	Narcotic analgesic	S8 (SCM)
Paracetamol	PO, PR	Analgesic	S2
Paracetamol Codeine	PO	Analgesic	S2-S4
Phenoxymethylpenicillin	PO	Antibiotic	S4
Pholcodine	PO	Cough Suppressant	S3
Permethrin	Top	Scabies treatment	unscheduled
Prednisolone	PO	Steroid	S4
Prilocaine	Top	Topical Anaesthetic	S4
Prochlorperazine	PO	Antiemetic	S4
Promethazine Hydrochloride	PO	Antihistamine	S4
Pseudoephedrine	PO	Decongestant	S3
Pyrantel	PO	Anthelminitics	S2
Ranitidine	PO	H_2 antagonist	S4
Roxithromycin	PO	Macrolide	S4
Salbutamol	INH	Bronchospasm relaxants	S4
Silver nitrate	Top	Cauterizing agent	Unscheduled
Silver Sulphadiazine	Top	Antibacterial burn treatment	S4
Sodium Citrotartrate	PO	Urinary Alkaliniser	Unscheduled
Sodium Phosphate	PR	Laxative	Unscheduled
Sodium Picosulfate	PO	Laxative	S3

Drug	Route	Therapeutic Class	Poisons Schedule
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Trimethoprim	PO	Antibiotic	S4
Sulfamethoxazole Trimethoprim	PO	Antibiotic	S4
Immunoglobulin (Zoster, Anti D, NHIG, other in response to ACT public Health Advice.	IM, SC	Immunoglobulin	S4
Vaccines (ADT, Boostrix, MMR, other in response to ACT public Health Advice.	IM	Vaccine	S4
Valaciclovir	PO	Antiviral	S4

Intravenous Fluids
Crystalloid - 0.9% Normal Saline, 4% Dextrose 1/5 Normal Saline, Hartmann's Solution, 5% Dextrose

A medication not on this list may be considered on the advice or order of a senior medical officer.

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ACT Government Health

CANBERRA HOSPITAL AND HEALTH SERVICES

Nurse Practitioner

Clinical Practice Guidelines

Nurse Practitioner: Michael Holroyd

AHPRA No: NMW0001390808

Health setting: Walk-in Centre ACT Government Health Directorate

Settings:

The Walk-in Centre (WiC) is a service within the ACT Government Health Directorate and is supported by the Commonwealth Government under their Primary Health care strategy. The WiC provides acute, episodic care for minor illnesses and injuries. The Nurse Practitioner (NP) has a permanent NP position within the WiC and works amongst a team of Advanced Practice Nurses (APN's) and a Clinical Nurse Consultant (CNC) to provide episodic health care services to the residents of the Australian Capital Territory and surrounds. The Nurse Practitioner may also be required to support and lead (as appropriate) outreach services or clinics in response to public health emergencies, pandemics or disasters-natural or otherwise.

Nurse Practitioner Role:

The WiC NP is a senior member of a nurse led team which provides primary, secondary and tertiary disease prevention and health promotion in the context of acute episodic care for minor illness and injury. The NP will use expert clinical nursing practice to assess and treat autonomously and collaboratively patients presenting for episodic care of minor illness and injuries. Therapeutics, referral processes, and diagnostics used for this role are included in this document and serve as the base role for this NP.

This NP may also work within an Emergency Department or Emergent care setting. The NP will use expert clinical nursing practice to assess and treat autonomously and collaboratively patients presenting to the department. Any seriously injured or unwell patients will be treated in collaboration with a senior medical officer. Care may be initiated by the NP, and 'handed-over' to the senior medical officer. Therapeutics, referral processes, and diagnostics used in this role are included in this document.

Client/ Patient Population:

In the WiC the NP manages patients aged two years and older who present with conditions appropriate symptomology to his skill and knowledge.

The Nurse Practitioner may treat more complex patients, or patients with other comorbidities. He will consult widely with patients' general practitioner, or Registrars from other specialties, for example Obstetrics and Gynaecology.

NB: This NP also has a Graduate Diploma in Paediatric and Child Health Nursing. This may be used in an outreach clinic in response to public health emergencies.

Date of Approval: .....

Review Date:

Update and review three years from date of guideline approval and third yearly thereafter. Update and review may occur more frequently as per the discretion of the NP (with significant changes in evidenced based practice or changes in practice setting/ collaborative agreement).

Disclaimer:

This document reflects current safe clinical practice. However, as in all clinical situations there may be factors which cannot be governed or guided by a single set of guidelines. This document does not replace the need for application of expert clinical judgement to each individual presentation.

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Local Service Area Clinical Practice Guideline Advisory Committee Members

Name	Position	Professional Qualifications	Organisation	Signature	Date
Gayle Comyn	NP WiC	RN MSN (NP)	ACT Health		13.10.13
Naree Stanton	ADON WiC RADAR / ACALU	B App Sci	ACT Health		22/10/13
Michelle Lambert	CNC WiC	B App sci	ACT Health		24/10/13
Tanya Robertson	Medical Officer	MBBS Hons FRACGP	ACT Health		22/10/13
Gabrielle Cooper	Pharmacist, Associate Dean	B Pharm DHP PhD	University of Canberra		29/10/13
Margaret McCulloch	Consumer Representative		Health Care Consumers Association of the ACT		24/10/13

Evidence of Additional Health Professional and/or stakeholder Consultation

The following Health care Professionals and stakeholders were consulted throughout the development phase of these Clinical Practice Guidelines. This was achieved via individual meetings, email, and/or telephone. Prior to meetings draft Clinical Practice Guidelines were delivered for review, comment and appraisal.

Name	Position	Professional Qualifications	Organisation	Rationale for consultation
Allison Jordan	NP	RN MN (NP)	Calvary Healthcare	NP in Emergency care
Murali Guduguntla	Consultant radiologist/ Director	MBBS	ACT Health	Medical Imaging advice
Irene Rotenko	Emergency Consultant	MBBS FACEM	Calvary Healthcare	Emergency advice
Peter Grant	Emergency consultant	MBBS FACEM	Calvary healthcare	
Christopher Helms	NP	RN MSN (NP)	West Belconnen Health Cooperative	Primary care
Rhonda Maher	DON RACC	B App Sci MS Health Management	ACT Health	Managerial advice

Introduction

The NP is a Registered Nurse (RN) who is authorised to provide an expert level of health assessment, management, and clinical care to patients presenting to the WiC. The NP model of care reflects the extended scope, specialty skills, and knowledge that is required for the role of NP, as described in the Australian Nursing and Midwifery accreditation Council's *Standards for Endorsement as a Nurse Practitioner.* This clinical guideline outlines the extended scope of clinical practice and will enable the NP to work safely and effectively in the delivery of advanced expert nursing care to patients.

The NP is a holistic practitioner. The NP's practice is underpinned by the principles of the World Health Organisations' (WHO) *Declaration of the Alma-Ata* of 1978 and the WHO 2008 document Primary Health Care (Now More than Ever). Accordingly the care afforded by the NP would include the following characteristics:

- build therapeutic relationships;
- provide comprehensive and person-centred care;
- target clients who experience significant barriers to accessing health services, thereby aiming to decrease the discrepancy in health within our community;
- empower clients to be partners in managing their own health and that of their community;
- build client's capacity for greater health and wellbeing; and
- address the determinants of ill-health through inter-sectoral collaboration with other government and non-government organizations.

The range of conditions that clients present with are very broad and it is expected that, in addition to core general practice experience and skills, the NP will also contribute individually unique expertise and skills based on their further education, previous professional and clinical specialty experience and/or interests.

The scope of practice for the NP will be dynamic and as he completes additional education and training it is anticipated that his case mix will diversify in keeping with service delivery requirements within the scope of his acquired skills and expertise. If the NP determines that a client or condition falls outside of his education, training, or expertise he will default to the practice setting's individual protocols or guidelines for management. If this, in turn, does not safely and effectively address the client's needs the NP will either refer the client to the appropriate healthcare provider or consult with a senior collaborating medical officer for further advice and/or treatment. This collaborative process will be clearly documented in the client's record and effectively communicated to all parties involved in the client's care.

The NP is responsible for maintaining an up-to-date scope of practice and is expected, that practice, in line with other health professionals, will be based on sound clinical judgement using best practice guidelines and the latest available

evidence (See Reference List). This document provides an overarching framework to guide the clinical practice of the NP.

The NP is authorised to undertake complete medical histories, utilise validated risk assessment tools, and perform advanced physical examinations utilising skills appropriate for a scope of practice concordant with generalist practice.

The NP will work in consultation with the patient, their significant others and the multidisciplinary team to ensure that the patient is aware of their clinical condition, choices available to them and to ensure the most appropriate management plan is developed with the patient. Specific to the episodic care provided the NP will provide relevant follow up instruction and information for all patients they provide a service to including engagement of the patient's General Practitioner, or health care provider.

This document reflects what is currently regarded as safe clinical practice. However, as in any clinical situation there will be factors, which cannot be covered by a single set of guidelines. In these situations the NP will exercise the application of clinical judgement specific for each individual presentation.

Conditions for Urgent Referral to the Emergency Department

All medical emergencies (actual or suspected), and patients that fit the Medical Emergency Team (MET) calling criteria.

MET Criteria (Adult)

- Threatened airway
- Respiratory arrest
- RR < 5 or >36
- SaO2 < 90 % FiO2 R/A
- Cardiac arrest
- PR < 40 or >140
- Systolic BP < 90
- Sudden fall in GCS > 2 points
- Repeated or prolonged seizures

Any other patient that the NP is seriously concerned about that does not fit the above criteria.

The NP will call the MET or an ambulance as pertains to the environment the NP is working in.

Conditions for Semi-Urgent Referral to the Emergency Department, Specialist or Local Government Agency:

All conditions for urgent referral to the emergency department as listed above plus others including, but is not limited to:

- Acute neurovascular compromise
- Possible threatened pregnancy
- Complicated fracture
- Child at risk of harm
- Sexual assault
- Post surgical complication
- Unstable chronic health conditions
- Conditions which, if not treated in a semi-urgent manner, will cause an increased length of stay, increased morbidity or mortality, or permanent dysfunction. This may include, but is not limited to:
    - Chest Pain
    - Acute abdomen
    - Infection with systemic features
    - Urinary retention
    - Delirium
    - Testicular torsion
    - Bowel obstruction
    - Unexplained bleeding or pain
    - Severe dehydration
    - Life-threatening depression

The NP will discuss with these patients and refer them to an Emergency Department for review and ongoing management.

Conditions for Referral to another Healthcare Professional:

- Any compromising condition or new presentation of the following conditions, which includes but is not limited to:
    - Heart Failure, Coronary Heart Disease, Diabetes, Chronic Obstructive Airway Disease (COAD), Neurovascular Disease, Asthma, Malignant Hypertension, Dementia, Severe Depression, Psychosis, or Autoimmune Disease.
- Any compromising chronic condition that is unstable but unlikely to deteriorate quickly.
- Any non-urgent condition with an unusual presentation or response to treatment deemed to be outside the scope of practice by the NP which they feel needs assessment by a more experienced clinician.
- Any condition that would benefit from collaboration amongst healthcare professionals for the purpose of providing holistic and preventative care in

order to achieve optimal health outcomes. This may include, but is not limited to:

- Dietician, Occupational Therapy, Physiotherapy, Speech Pathology, and Audiometry.

- Review and/or renewal of regular, ongoing medication prescribed by another clinician for a condition that is not managed within the established NP Medication Formulary.
- Patients that the NP considers to be outside his expertise and do not fit into the urgent/semi-urgent referral pathway.

Management

Primary Prevention management strategies may include, but is not limited to:

- Health promotion activities within the service and to outside community groups; becoming aware of the gaps within our local community knowledge, and addressing these issues with the community themselves and through intersectoral collaboration.
- Ensuring appropriate health promotion resources are available in the service on a number of topics. Particular focus on Australia's National Preventative Health Strategies which target obesity, tobacco use & alcohol use.
- Safer sex education, provision of condoms, and advice.
- Immunisations.
- Dietary, smoking cessation, alcohol, and physical activity advice.

Secondary Prevention management strategies may include, but is not limited to:

- Sexually transmitted infection screening.
- Pregnancy testing.
- Periodic determination of blood pressure.
- Smoking cessation counselling.
- Dietary counselling.
- Weight loss counselling.

Tertiary Prevention management strategies include:
Disease management of common illnesses that do not have a chronic nature, but need to be treated to alleviate suffering of clients, ensure rapid return to workforce and to improve overall health. These conditions may include, but are not limited to:

- Head, Ears, Eyes, Nose, Throat (Acute Otitis Media, Acute Otitis Externa, Conjunctivitis, Sinusitis, Tonsillitis, Pharyngitis, Minor Dental Issues, Minor Epistaxis, Foreign Body/Insect).
- Respiratory (Upper / Lower Respiratory Infections, Acute Minor Asthma, Moderate Asthma, Minor Chest Infection).
- Gastrointestinal (Dyspepsia, Gastroenteritis, Constipation, Nausea, Vomiting, Intestinal Parasitic Infections).

- Genitourinary (Urinary tract Infections, Urethritis, Balanitis, Candidiasis, Mastitis, Foreign Body).
- Sexual & Reproductive Health (Mastitis, Sexually Transmitted Infections, Emergency Contraception, Minor 1st Trimester Vomiting).
- Musculoskeletal (Sprains/Strains, Uncomplicated Fractures, Uncomplicated dislocations, Pulled elbow, Contusions, Costochondritis, Plantar Fasciitis, Epicondylitis, Bursitis, Acute Gout, Torticollis, Uncomplicated Back Pain).
- Immunology and Toxicology (Allergic Reaction, Minor Insect Bites and Marine Stings).
- Neurology (Migraine with Previous History).
- Skin (Wound Care, Minor Thermal and Chemical Burns, Lacerations, Bites, Acute Minor Wounds, Wound Infections, Cellulitis Boils/Carbuncles, Dermatitis, Shingles, Varicella,
- Wound dressing, Plaster application, Immunisation

Appropriate referral will be made for conditions requiring ongoing investigation, treatment, contact tracing and follow-up (Example Sexually Transmitted Infections).

Diagnostic Investigations:

The NP may order the following studies to assist in the diagnosis and/or management of acute, episodic illnesses

Pathology

Full Blood Count (FBC)

Urea, Electrolytes and Creatinine (UEC)

Liver Function Test (LFT)

Erythrocyte Sedimentation Rate (ESR)

C Reactive Protein (CRP)

Calcium, Phosphate, Magnesium (CaPo4Mg)

Coagulation Studies (COAGS) consisting of: Activated Partial Thromboplastin Time (aPTT); Prothrombin Time (PT) including International Normalized Ratio (INR); Fibrinogen; D-Dimer

Beta HCG Pregnancy Assay

Thyroid Function Tests

Amylase

Anion Gap (AG) – Calculated

Bicarbonate (HCO3-)

Bilirubin Direct

Bilirubin Total

Calcium Ionised (iCa)

Chloride (Cl)

Glucose (BGL) fasting or random

Ferritin

Ketones

Lactate

Lipase

Microbiology

Direct microscopy, culture and antibiotic sensitivity of specimens including:-

Blood,
Faeces including ovae, parasites and cysts
Sputum,
Urine,
Nasal, oropharangeal, nasopharyngeal aspirate
Wound swabs (deep and superficial).
Eye and/or ear swabs
Cervical, vaginal and urethral
Fungal scrapings

Immunology and Immunodiagnostic

C Reactive Protein

Epstein Barr Virus

Pertussis

Rubella

Hepatitis A, B C

Varicella

Syphillis

Chlamydia

Gonorrhoea

Faecal Occult Blood

Medical Imaging

Plain Axial Skeleton

Plain Chest

Abdominal X-Ray

Diagnostic imaging that is interpreted prior to formal reporting will be reviewed by the Nurse Practitioner, with abnormal results prompting review per appropriate patient care.

Other investigations may be ordered upon discussion with a collaborating medical officer, general practitioner, or senior registrar.

Health Promotion/ Illness Prevention Strategies

This may include, but is not limited to:

- Immunisation
- Health literacy support materials
- Provision of consumer medicines information
- Lifestyle modification (diet and physical activity)
- Weight management
- Smoking cessation
- Safe sex
- Stress management
- Alcohol and other drug moderation
- Wound care
- Physiotherapy
- Hazard assessment
- Personal protective equipment

Non-Pharmacological Management Approaches

This may include, but is not limited to:

- Massage
- Pressure Area Management
- Diversional Therapy
- Pelvic Floor Exercises
- Self care strategies
- Rest
- Elevation
- Dressings, bandaging, compression, splint and sling
- Minor surgical procedures and suturing
- Condoms
- Crutches
- Hydration
- Skin care
- Hygiene
- Bowel management
- Thermoregulatory (ice/heat packs)
- Earwax removal

Pharmacological Management

Pharmacological management will include medications and oral rehydration preparations relevant to the management of injuries and illnesses appropriate for acute, episodic care. Examples of conditions requiring pharmacologic treatment in the context of acute, episodic care are:

- Ear, Eye, Nose, Sinus & Throat Infections
- Common Cold/ Influenza
- Upper & Lower Respiratory Tract Infections
- Acute Asthma & Chronic Obstructive Airway Disease exacerbations
- Gastrointestinal Infections
- Nausea/Vomiting
- Urinary & Sexual Transmitted Infections
- Emergency Contraception
- Constipation/Diarrhoea
- Fever
- Pain
- Skin & Wound Infections
- Allergy Symptoms
- Sprains and Strains
- Minor Fractures
- Minor Lacerations, Abrasions & Puncture Wounds
- Minor Burns
- Animal & Insect Bites
- Acute Gout
- Shingles
- Digital Nerve Blocks

Medication Formulary

The WiC NP is authorised to dispense/ prescribe to patients those medications contained in the formulary within the Nurse Practitioner Clinical Practice Guidelines.

It is the NP's responsibility to use this formulary in conjunction with the most recent Australian Medicines Handbook & Therapeutic Guidelines to identify the currently accepted correct dosage and duration of therapy, contraindications, precautions and adverse effects.

This formulary provides for the poisons and restricted substances that may be possessed, used, supplied or prescribed by Nurse Practitioners under section 17A of the Poisons and Therapeutic Goods Act 1966 and forms part of approved Nurse Practitioner guidelines.

Medication Formulary

Drug	Route	Therapeutic Class	Poisons Schedule
Aciclovir	PO, Top	Antiviral	S4
Adrenaline	Neb, IV, IM, SC	Adrenergic stimulants/vasopressor	S3
Amethocaine	Top	Local anaesthetic	S2
Amoxycillin	PO	Antibioitic	S4
Amoxycillin Clavulanic acid	PO	Antibiotic	S4
Anorectal products	PR	Laxative, analgesics	Unscheduled
Atropine	IV	Cholinergic/anticholinergic agent	S4
Aspirin	PO	Anti-inflammatory	Unscheduled
Aspirin Codeine	PO	Anti-inflammatory/Analgesia	S2
Azithromycin	PO	Antibiotic	S4
Beclomethasone	INH	Steroid	S2
Betamethasone Acetate	INH	Steroid	S4
Betamethasone Valerate	Top	Steroid	S4
Budesonide	INH	Steroid	S4

Drug	Route	Therapeutic Class	Poisons Schedule
Bupivacaine	SC	Local anaesthetic	S4
Cefaclor	PO	Antibiotic	S4
Cefuroxime	PO	Antibiotic	S4
Celocoxib	PO	Antiinflammatory	S4
Cephalexin	PO	Antibiotic	S4
Chloramphenicol	Top	Antibiotic	S4
Ciprofloxacin	PO	Antibiotic	S4
Clarithromycin	PO	Macrolide	S4
Clindamycin	PO	Macrolide	S4
Clotrimazole	Top, PO	Antifungal	S2
Colchicine	PO	Musculo skeletal	S4
Dexamethasone	PO, IM, IV	Steroid	S4
Dextrose 50%	IV	Dextrose	Unscheduled
Diazepam	PO	Anti anxiety agents/ Anticonvulsant	S4
Diclofenac	PO	Antiinflammatory	S4
Dicloxacillin	PO	Antibiotic	S4
Diphenylhydramine	PO	Antihistamine	S2
Docusate	PO	Laxative	Unscheduled
Docusate Senna	PO	Laxative	Unscheduled
Domperidone	PO	Antiemetic	S4
Doxycycline	PO	Antibiotic	S4
Ear Preparations	Top	Steroid, Antibiotic	S4
Electrolyte Solutions	PO	Electrolytes	S4
Erythromycin	PO	Antibiotic	S4

Drug	Route	Therapeutic Class	Poisons Schedule
Esomeprazole, Lansoprazole, Omeprazole, Pantoprazole, Rabeprazole	PO	Proton Pump Inhibitor	S4
Famciclovir	PO	Antiviral	S4
Flucloxacillin	PO	Antibiotic	S4
Fluconazole	PO	Antifungal	S4
Frusemide	PO	Diuretic	S4
Flourescein	Top	Ophthalmic agent	Unscheduled
Fluticasone Salmeterol	INH	Preventative aerosol	S4
Gastrogel, Mylanta, Gaviscon	PO	Antacid	S2
Glucagon	SC, IM	Anti Hypoglycaemic	S4
Glucocorticosteroid	INH	Steroid	S4
Glucose	PO	Anti hypoglycaemic	Unscheduled
Homatropine	Top	Mydriatic	S4
Hydrocortisone	Top	Steroid	S4
Hyoscine Butylbromide	PO	Antispasmotic	S4
Hypromellose Dextran, Antazoline/ Naphazoline, Ketotifen, Acular, Diclofenac sodium	Top	Ocular lubricant, anti histamine, NSAID, Analgesia	Unscheduled, S4
Ibuprofen	PO	Anti-inflammatory	S2
Ibuprofen / Codeine	PO	Anti Inflammaory	S3
Indomethacin	PO, PR	Anti-inflammatory	S4
Ipratropium bromide	INH	Bronchodilator aerosols & inhalation	S4

Drug	Route	Therapeutic Class	Poisons Schedule
Ivermectin	PO	Anthelminitics	S4
Kenacomb	Top	Steroid	S4
Ketorolac	IM, PO	Anti-inflammatory	S4
Levonorgestrel	PO	Contraceptive	S3
Lignocaine	SC	Local anaesthetic	S2
Lignocaine adrenaline	SC	Local anaesthetic	S3
Lignocaine	Top	Anaesthetic	S4
Lignocaine chlorhexadine	Top	Anaesthetic gel	S4
Xylocaine viscous	PO, Top	Anaesthetic	S3,
Lignocaine prilocaine	Top	Anaesthetic cream	S4
Loperamide	PO	Antidiarrhoeals	S2
Loratidine, desloratadine, Cetirizine, Fexofenadine, Dexchlorpheniramine, Trimeprazine	PO	Antihistamine	S2, S3
Macrogol/ Movicol	PO	Laxative	Unscheduled
Mometasone	Top	Steroid	S4
Metoclopramide	IM, PO, IV	Antiemetic	S3
Midazolam	PO,IN	Sedative/Hypnotics	S4
Miconazole	Top	Antifungal	S2
Morphine	IM, SC	Narcotic analgesic	S8
Mupirocin	Top	Antiviral	S4
Naloxone	IM, IV	Opioid Antagonist	S4
Naproxen	PO	Antiinflammatory	S4
Norfloxacin	PO	Antibiotic	S4

Drug	Route	Therapeutic Class	Poisons Schedule
Omeprazole	PO	Proton Pump Inhibitor	S4
Ondansetron	SL, PO	Antiemetic	S4
Osteltamivir	PO	Antiviral	S4
Oxygen	INH		
Oxycodone	PO	Narcotic analgesic	S8
Paracetamol	PO, PR	Analgesic	S2
Paracetamol Codeine	PO	Analgesic	S2-S4
Phenoxymethylpenicillin	PO	Antibiotic	S4
Pholcodine	PO	Cough Suppressant	S3
Permethrin	Top	Scabies treatment	unscheduled
Prednisolone	PO	Steroid	S4
Prilocaine	Top	Topical Anaesthetic	S4
Prochlorperazine	PO	Antiemetic	S4
Promethazine Hydrochloride	PO	Antihistamine	S4
Pseudoephedrine	PO	Decongestant	S3
Pyrantel	PO	Anthelminitics	S2
Ranitidine	PO	H_2 antagonist	S4
Roxithromycin	PO	Macrolide	S4
Salbutamol	INH	Bronchospasm relaxants	S4
Silver nitrate	Top	Cauterizing agent	Unscheduled
Silver Sulphadiazine	Top	Antibacterial burn treatment	S4
Sodium Citrotartrate	PO	Urinary Alkaliniser	Unscheduled
Sodium Phosphate	PR	Laxative	Unscheduled
Sodium Picosulfate	PO	Laxative	S3
			Poisons

Drug	Route	Therapeutic Class	Schedule
Terbinafine	PO	Antifungal	S4
Trimethoprim	PO	Antibiotic	S4
Sulfamethoxazole, trimethoprim	PO	Antibiotic	S4
Immunoglobulin (Zoster, Anti D, NHIG, other in response to ACT public Health Advice.	IM, SC	Immunoglobulin	S4
Vaccines (ADt, Boostrix, MMR, other in response to ACT public Health Advice.	IM	Vaccine	S4
Valaciclovir	PO	Antiviral	S4

Intravenous Fluids
Crystalloid - 0.9% Normal Saline, 4% Dextrose 1/5 Normal Saline, Hartmann's Solution, 5% Dextrose

A medication not on this list may be considered on the advice or order of a senior medical officer.

Medications and methods of administration used in advanced life support may be given by the Nurse Practitioner in life threatening situations. An examples is adrenaline via intraosseous or endotracheal tube administration

Other medications that are not listed above, that are available "over the counter", such as schedule 2 or 3 medications may be recommended by the Nurse Practitioner.

Follow Up Care

This would include, but is not limited to:

- Monitor test results and communicate to patient and relevant/collaborating healthcare professionals (Example GP, Emergency Department, Allied Health). Diagnostic tests that are ordered by the NP are to be followed up and actioned by that NP in a safe and timely basis, unless arranged previously with another NP. This will require After-Hours access to the ACT Health Network.
- Evaluate therapeutic response
- Management of abnormal results within scope of practice (Example wound culture)
- Monitor Progress

Plan for dissemination of Clinical Practice Guidelines

The WiC NP Clinical Practice Guidelines will be posted on The ACT Government Health- Directorate website.

- Copy held at the Office of the Chief Nurse, ACT Health
- Copy held at the WiC, The Canberra Hospital
- Copy lodged with the Australian College of Nurse Practitioners

Plan for Implementation of Clinical Practice Guidelines

The NP will implement the full scope of practice once approval has been gained.

Plan for review and revision of Clinical Practice Guideline.

Update and review three years from date of guideline approval and third yearly thereafter. Update and review may occur more frequently as per the discretion of the NP (with significant changes in evidenced based practice or changes in practice setting/ collaborative agreement).

Reference list/ Bibliography

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ACT Government
Health

Walk-in Centre:
Clinical Treatment Protocols

June 2014
Version 2014 - 3

Version Control

Version	Date	Modifications
1.0	1 February 2010	First draft
2.0	18 February 2010	Following Executive Reference Group: 1. Genitourinary Clinical Impressions 2. Headache Clinical Impressions
3.0	1 March 2010	1. Addition of Ear Conditions Treatment Protocol
4.0	17 March 2010	Following Clinical Board: 1. Asthma Clinical Impression 2. Upper Respiratory Tract Infection Treatment Protocol 3. Fever Information Sheet 4. Migraine Information Sheet 5. Allergic Conjunctivitis Protocols 6. Fungal Infections Information Sheet 7. Impetigo Clinical Impression 8. Varicella Information Sheet 9. Measles Clinical Impression 10. Tonsillitis Treatment Protocol 11. Influenza Treatment Protocol 12. All Musculoskeletal Treatment Protocols
5.0	29 March 2010	1. Anaphylaxis Treatment Protocol 2. Eye Treatment Protocols 3. Asthma Clinical Impression 4. Hand Injury Clinical Impression 5. Otitis Media Treatment Protocol
6.0	1 April 2010	"Medication Protocol' changed to read Medication Standing Order on all Treatment Protocols
6.1 Final Version	9 April 2010	Add introduction Add review dates to all Treatment Protocols Change of page numbers
6.2	28 April 2010	• Addition of TCH to footer • Abbreviations list added • Amendment to Burns Treatment Protocol (p 57 & p93) • Addition of guiding statement to Registrar consultation process for: pregnancy (p19), burns (p57), bites (p 72), lacerations (p 51), scaphoid fracture (p159), ankle injury (p169), finger/toe injury (p 180) and fractures (p 198) • Change to Clinical Impressions treatment wording regarding MET / Ambulance (p1, p15, p 60) • Contents list reordered to an alphabetical list • Grammatical and typographical corrections throughout document • 'patient' renamed to 'client' throughout document
6.2	August 2010 Review (approved by WiC Clinical Advisory Group)	• Fracture Treatment Protocol – Change scaphoid cast to scaphoid back slab • Laceration Treatment Protocol & Otitis Externa Treatment Protocol – Date for therapeutic Guidelines and AMH changed • Atopic Dermatitis (Eczema) – Addition to expected symptoms

Version	Date	Modifications
		• Boil Carbuncle Treatment Protocol Addition to Non-fluctuant boils/carbuncles – apply moist heat 3-4 times daily to relieve discomfort, help locate infection and promote drainage. Addition under advise – see GP for follow up in 2 days ,or if not responding to 48 hrs of antibiotic treatment, may need swab for culture and sensitivity. • Diarrhoea - Redirection to GP not ED for diarrhoea with pus/mucous. Change anti-diarrhoeal to anti-spasmodic. • Gastroenteritis – Hyper emesis - add redirection to Obs and Gynae Reg/GP. Change to advice for clients taking pill Gastrolyte R to Oral Rehydration Fluid. • Fungal Infection – new treatment protocol added. • Scabies – new treatment protocol added • Wound Dressing – new protocol • Suture Removal – new protocol • Shingles - Redirection to GP same day or if not possible ED • Blood Glucose Protocol – new treatment protocol added
6.2	30 November 2010 Review (approved by WiC Clinical Advisory Group)	• Dog or Cat bite – add "If redness or swelling increases you should see your GP • Foot Sprain Patient information sheet – change "toe" to "foot." • Addition – Fungal Infection WiC Information Sheet • Addition – Scabies Treatment Protocol
6.2	3 February 2011 Review (approved by WiC Clinical Advisory Group)	• Elbow Sprain or Strain protocol – delete "consider use of crutches" and delete "results should be discussed with plastics registrar" (leave "orthopaedic registrar" only). • Knee Sprain or Strain protocol – redirection for minor ligament injuries disposition changed to include redirection to GP • Subungual Haematoma – New Protocol • Laceration Treatment Protocol – requirement for consultation with Plastics Registrar modified
6.2	31 May 2011 Review (approved by WiC Clinical Advisory Group)	• Updated Asthma protocol including changes to oxygen saturation levels to be made consistent throughout protocol.
6.2	11 April 2012 Review (approved by WiC Clinical Advisory Group & endorsed by RACC Quality Committee)	• Addition of Blood Alcohol Testing Standard Operating Procedure in the WiC endorsed by Rehabilitation Aged and Community Care Quality Committee.
6.2	Endorsed by CAG and CHO	• Addition of new protocol – treatment for Measles contacts (valid for discrete time period)
6.2	13 August 2012	• New section added – Public Health Promotion/Screening
7.0	10 September 2012	• Endorsement of complete Version 7.0 WiC Protocols by Rehabilitation Aged and

Version	Date	Modifications
		Community Care Quality Committee.
13.1 (note:This version follows V 7.0 to align with the year)	Approved by RACC Exec Quality and Safety Committee 11 Feb 2013	• Review of the following protocols conducted: Upper Respiratory Tract Infections, Bites and Stings, Fever, Foot Conditions, Fracture Management, Headache, Limb Muscle Injury, Registrar Review Clinic Referral Coversheet, Wounds and Lacerations. No changes were recommended – expiry dates revised to 30 November 2014. Same tabled and agreed by WiC Clinical Advisory Group 27 November 2012.
2014 – version 2	Approved by RACC Exec Quality and Safety Committee May 2014	• Mastitis Protocol and Clinical Impression
2014 V3	Endorsed by the WiC Clinical Advisory Group 17 June 2014. Approved by RACC Executive Quality and Safety Committee XX Insert Date	• Change use of Epipen to Adrenaline to reduce costs • All references to MET call changed to call Ambulance 0 000 • Allergic Conjuntivitis – change MSO to Albalon A, previously Antistine-Privine which is no longer available • Dry Eye Treatment Protocol – remove Schirmer Test due to the pain that it may cause for client • Headache Protocol – change disposition from refer to ED to call ambulance 0 000 for headache associated with fever and rash/neck stiffness • Headache Protocol – change disposition from refer to ED to call ambulance in headache associated with changes in consciousness • Mental Health Self Harm – change from redirect to CATT to contact CATT as clients require immediate assistance • Mental Health Threat to Person or Property – change from redirect to ED to call duress and call police 0 000 & follow ACT Health Security Policy • Mental Health suicide – change from redirect to ED to Contact CATT • Mental Health Anxiety and Depression – change from redirect to CATT to GP • Mental Health Psychosis – change from Redirect to ED to call ambulance/police 0 000 • Sexual Health sexual assault – change disposition to call FAMSAC • Sexual Health Contraception Advice – additional advice re IUDs • Wounds and Lacerations – Infected wound add NP review in addition to GP • Laceration Treatment Protocol – remove cleaning and closure of wounds to be conducted in treatment room as all clinical rooms are used for this procedure • Wounds and Lacerations Infected Wound – add NP disposition as an option

Version	Date	Modifications
		• Burns Treatment Protocol – Remove debriding non viable superficial tissue • Suture Removal Treatment Protocol – change disposition from refer to ED to GP or NP Review • Asthma Clinical Impression – add aim to keep oximetry to >90% • URTI Recurrent Non Specific Cough /Chronic Bronchitis/Bronchiectasis/Exercise Induced Dyspnoea – include NP review and redirection to GP • Sting Treatment Protocol – add use fine pointed tweezers or tick remover as appropriate • Marin Stings – remove from protocols (this has not been used in four years of WiC operations • Gastroenteritis – melaena and diarrhoea in presence of pus or mucous change from redirect ot ED to redirect to GP/NP • Diarrhorea Treatment Protocol – Removal of "Diluted Soft Drinks" • Menigitis Protocol – change redirection from ED to Call Ambulance • Scabies Protocol – Only redirect to GP is concerns of "Crusted Scabies" • Shingles Protocol – change to refer to GP within 72 hrs of rash onset • Boil Carbuncle Protocol – add option to refer to NP in addition to GP • Paronychia Protocol - remove lignocaine/adrenaline from MSO • Sinusitis Protocol – change to treat with antibiotics if symptoms present > 7 days. • Fractured Knee Protocol – change redirect to ED to Reg Review Clinic • Knee/Wrist/Ankle/Elbow infection – add option to redirect to NP as well as GP • Finger/Toe/Foot/Hand infection - add option to redirect to NP as well as GP • Hand Sprain information sheet remove "submerge hand in iced water for first two days" • Mild and Moderate Cellulitis – add NP review to redirection options as well as GP • Ear Wax Treatment Protocol – include verbal consent to treat • Otitis Media Protocol – add "otitis media is commonly related to an upper respiratory tract infection and as such is normally associated with a viral infection. As such antibiotics are not indicated. • Blood Glucose Protocol – Change call MET to call ambulance

Abbreviation	Detail
ACT	Australian Capital Territory
UK	United Kingdom
ADT	Adult Diphtheria and Tetanus Booster
ASAP	as soon as possible
SHFPACT	Sexual Health and Family Planning ACT
CHO	Chief Health Officer
FAMSAC	Forensic and Medical Sexual Assault Centre
CATT	Crisis Assessment and Treatment Team
ED	Emergency Department
e.g.	example
GP	General Practitioner
HIV	Human Immunodeficiency Virus
IUD	Intrauterine Device
NAD	Non adherent dressing
ROS	Removal of sutures
CSL	Commonwealth Serum Laboratories
RACGP	Royal Australian College of General Practitioners
MET	Medical Emergency Team
NPS	National Prescribing Service
IDC	Indwelling urethral catheter
SPC	Suprapubic Catheter
L	Left
N/A	Not applicable
PID	Pelvic Inflammatory Disease
STI	Sexually Transmitted Infection
UTI	Urinary Tract Infection
HCG	Human Chorionic Gonadotrophin
NSAID	Non-Steroidal Anti-Inflammatory Drugs
R	Right
TCH	The Canberra Hospital
PV	Per vagina
WiC	Walk-in Centre

Contents

Introduction

The treatment protocols contained in this document apply only to the Walk-in Centre (WiC) located at the Canberra Hospital, Yamba Drive, Garran ACT. Further WiCs, at different locations may be introduced in the ACT at a future date and the Treatment Protocols and Standing Orders will need a complete revision and re-approval before use at any other site.

Additionally, the standing orders are only for use by the WiC Registered Nursing Staff (nurses, Advance Practice Nurses and Nurse Practitioners) in conjunction with the approved WiC Medication Standing Orders.

The Treatment Protocols contained in this document must be reviewed and re-approved by the date nominated at the bottom of the relevant protocol. The procedure for this is contained in the WiC Operational Model of Care.

The original version was written using the latest clinical evidence and the expertise of the members of the Walk-in Centre Clinical Working Group.

Members of the original Clinical Working Group included:

- Clare Willington, GP Advisor, ACT Health
- Sanjaya Senanayake, Medical Director, Ambulatory Care, TCH
- Neil Keen, Director of Pharmacy, TCH
- Lisa Gilmore, Acting Director Physiotherapy, TCH
- Jo Morris, Physiotherapist, TCH
- Jane Desborough, Nursing and Midwifery Office Project Leader, ACT Health
- Jane Frost, Access Improvement Program Project Leader, ACT Health
- Tanya Dufty, Director of Nursing, Ambulatory and Medical Services, TCH
- Matt Luther, Nurse Practitioner Calvary Hospital and WiC Project Support
- Charmaine Gray, ACT Pathology
- Miriam Lawrence, Pharmacist, TCH
- Naree Stanton, Assistant Director of Nursing, Walk-in Centres, ACT Health
- Shane Cumberland and Sheryl Harrison, Access Improvement Program, ACT Health
- Susan Hayward, Project Manager, Access Improvement Program, ACT Health

All WiC protocols have been revised by the Walk-in Centre team members within the first year of operations according to an agreed schedule. These require review after two years. New protocols have been added. New protocols will require review after one year. Protocols are to be presented to the WiC Clinical Advisory Group for their recommendations and endorsement and then approval is to be sought by the Rehabilitation Aged and Community Care Quality Committee.

Clinical Impressions:

Anaphylactic Reaction

Condition	Criteria	Treatment
Anaphylaxis	• Persons presenting with a complaint of an allergic reaction with the following symptoms: ○ Difficulty breathing ○ Swelling of the tongue ○ Swelling of the throat ○ Difficulty talking ○ Wheezing with a persistent cough ○ Children who are pale and floppy + or – any of the above ○ Hives, welts and/or skin redness • Persons developing the above symptoms post medication administration or examination	• Call ambulance • Anaphylaxis Treatment Protocol

References:

- National Health Service Institute for Innovation and Improvement: Clinical Knowledge Summaries

Anaphylaxis Treatment Protocol

Treatment

- External assistance from the AMBULANCE should be summoned immediately upon recognition of the anaphylactic reaction
- Symptoms affecting the cardiovascular and respiratory systems should be managed with supplemental oxygen and intramuscular Adrenaline whilst awaiting further assistance.
- Consideration and preparation" s for basic/advanced life support interventions should be commenced.
- Intravenous access should be established as soon as possible.

Advice

- Anaphylaxis is an immediate life threatening condition
- Anaphylactoid reactions should be managed in the same manner as an anaphylactic reaction
- Anaphylactic reactions may occur after the consumption of some food types (eg nuts or shellfish), the administration of medications (including alternative therapies), being bitten by a venomous creature (eg a bee sting) or from exposure to another substance (eg latex)
- The client should be advised to seek medical attention immediately if they recognise the symptoms of an impending anaphylactic reaction
    - Difficulty breathing
    - Swelling of the tongue
    - Swelling of the throat
    - Difficulty talking
    - Wheezing with a persistent cough
    - Pale and floppy (children) + or – any of the above symptoms
    - Hives, welts and/or skin redness
- The client should seek specialist advice as to the creation of an Anaphylaxis Action Plan, including the possible prescription and dispensing of an 'EpiPen'®, then carrying the device with them at all times

Medication Standing Orders

- Adrenaline

References	
• UK National Health Service Institute for Innovation and Improvement: Clinical Knowledge Summaries 2009	• Therapeutic Guidelines, 2009 • Australian Medicines Handbook, 2009
Approval	
Date of effect:	18 May 2010
Date reviewed:	31 May 2011, 12 March 2014
Next Review Due:	12 March 2016

Breast Conditions

Condition	Criteria	Treatment
Infectious Lactational Mastitis	• Women presenting with: a hard, red, tender, swollen area of one breast or both breasts and other systemic symptoms including fever, chills, tachycardia, myalgia, headache, flu-like symptoms, +/- axillary lymphadenopathy. In the absence of a fluctuant, tender, palpable mass.	• Infectious Lactational Mastitis Treatment Protocol. • Non Pharmacological measures. • Mastitis information pamphlet. • Review by GP and if recurrent, seek lactation consultant review
Breast Abscess	• The presentation of a breast abscess is similar to mastitis, with localized, painful inflammation of the breast associated with fever and malaise, along **with a fluctuant, tender, palpable mass.**	• Refer to ED protocol
Inflammatory Mastitis	• An absence of systemic symptoms, normal breast appearance with a hard area, or red, hard and tender area of one breast.	• Non Pharmacological measures • Refer to NHMRC guideline • Mastitis information pamphlet
Nipple trauma	• Women presenting with cracked and sore nipples	• Cracked and sore nipple information sheet • Positioning and attachment sheet • Refer to NHMRC guideline
Candida	• Women presenting with sore	• Thrush information sheet.

Infection	nipples, burning or itching and possibly shooting pain deep into the breast.	• Refer to GP
Engorgement	• For most susceptible women, engorgement peaks at about 3-5 days post delivery as a result of increased milk production, and slowly recedes, but may last up to 2 weeks for some.	• Non-pharmacological measures • Refer to NHMRC guideline
Blocked Duct	• A tender lump in an otherwise healthy breastfeeding mothers breast due to a blockage of one or more of the collecting ducts. The milk backs up behind the blockage causing inflammation of the breast tissue	• Non-pharmacological measures • Positioning and attachment brochure • Refer to NHMRC guideline
Breast Cancer	• Any mass that shows no decrease in size after 72hrs of treatment, afebrile mastitis-like symptoms that are unresolved after a course of antibiotics, recurrent mastitis or blocked ducts that appear at the same location.	• Refer to GP protocol

References:

- Brodribb,W.(2004). *Breastfeeding Management. 3rd ed.* Australian Breastfeeding Association.
- Walker, M (2006) Breastfeeding management for the clinician using the evidence. Jones and Bartlett MA.
- Riordan, J & Wambach, K.(2010).Breastfeeding and Human Lactation. Fourth Ed. Sudbury: Jones and Bartlet Publishers.
- Therapeutic Guidelines.
- http://www.uptodate.com/contents/lactational-mastitis?source=search_result&search=mastitis&selectedTitle=1%7E55
- http://www.thewomens.org.au/BreastfeedingClinicalPracticeGuidelines?searchTerms[]=mastitis
- http://www.nhmrc.gov.au/guidelines/publications/n56

Infectious Lactational Mastitis Treatment Protocol

Treatment

- Infectious mastitis should be a considered diagnosis for all lactating women presenting with: a hard, red, tender, swollen area of one or both breasts **and** other systemic symptoms including one or more of the following; fever, chills, tachycardia, myalgia, headache, flu-like symptoms,+/- axillary lymphadenopathy.

NB: These symptoms are often rapid in onset.

- Differential diagnosis; inflammatory mastitis, engorgement, blocked duct, breast abscess, breast cancer.
- Other conditions to be aware of : candida infection, nipple trauma
- A thorough clinical history and physical assessment will identify lactational mastitis risk factors such as; previous history of mastitis, damaged and/or infected nipples, inadequate milk drainage, blocked ducts, blocked nipple pore/white spot, immunocompromised states e.g. diabetes or certain medications abrupt weaning, fatigue, stress, poor health, change in feeding frequency, abundant milk supply, infection in the household, bacteria contamination from the infants nose/mouth, mothers hands or nipple cream, trauma to the breast, restrictive clothing.

- For Infectious mastitis –

1. Administration of antibiotics as per standing order;
2. Provide symptomatic relief. Anti-inflammatory agents ie ibuprofen as well as cold compresses or ice packs reduce local pain and swelling.
3. Improve breast feeding techniques. Continued breastfeeding should be encouraged; treatment does not usually require cessation of breastfeeding. Breast emptying is essential during the course of treatment. There is minimal risk of passing any infection on to the infant.

- Symptoms of inflammatory mastitis include; an absence of systemic symptoms, normal breast appearance with a hard area, or red, hard and tender area. Inflammatory mastitis should be treated using non-pharmacological measures.

Advice

- **Non-pharmacological treatment advice**; Effective drainage of breast milk to maintain supply and reduce the risk of abscess formation is essential for all forms of lactational mastitis. IE:
    1. **Drain the breast often**, at least 8-12 times every 24hrs either by breastfeeding or expressing,
    2. Apply warmth prior to feeding,
    3. Apply cold compress following the feed to decrease swelling and relieve pain,
    4. Feed from the sore breast first,
    5. Massage the affected breast gently while feeding, and while showering/bathing. Massage from the affected area towards the nipple.

- Hydration
- Rest
- Refer to MACH services at the next available day for ongoing breastfeeding support and +/- ongoing referral to physio, +/- lactation consultant
- Refer to GP after 48hrs for F/U and assessment
- Provide and explain the client information pamphlets(HD), +/- WIC specific information sheet.
- Inform the client that if there is no improvement in condition/worsening of condition despite care advice – to seek medical attention.
- Educate re signs of abscess formation - The presentation of a breast abscess is similar to mastitis, with localized, painful inflammation of the breast associated with fever and malaise, along **with a fluctuant, tender, palpable mass.**

Medication Standing Order

- Dicloxacillin 500mg orally 6 hourly for at least 5 days.
- If allergic to penicillin Cephalexin 500mg orally 6hrly for at least 5 days
- If there is a history of immediate penicillin hypersensitivity client needs GP review
- Paracetamol
- Ibuprofen

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- Brodribb,W.(2004). *Breastfeeding Management. 3rd ed.* Australian Breastfeeding Association.
- Walker, M (2006) Breastfeeding management for the clinician using the evidence. Jones and Bartlett MA.
- Riordan, J & Wambach, K.(2010).Breastfeeding and Human Lactation. Fourth Ed. Sudbury: Jones and Bartlet Publishers.
- Therapeutic Guidelines.
- http://www.uptodate.com/contents/lactational-mastitis?source=search_result&search=mastitis&selectedTitle=1%7E55
- http://www.thewomens.org.au/BreastfeedingClinicalPracticeGuidelines?searchTerms[]=mastitis
- http://www.nhmrc.gov.au/guidelines/publications/n56

Approval

Date of effect: 12 March 2014

Date of review: 12 March 2016

Clinical Impressions:

Eye Conditions

Condition	Criteria	Treatment
Foreign body of the eye	• Persons presenting with an eye complaint • On examination a foreign body is identified on the corneal surface of the eye or eyelid that is not mobile	• Redirect to ED Protocol
Eye trauma	• Persons presenting with an eye complaint • Persons state that they have sustained a trauma to the eye leading to their presentation • Be aware of high impact eye injuries eg grinding, chopping wood or hammering metal etc, Foreign bodies may penetrate the eye causing little discomfort.	• Redirect to ED Protocol
Infective conjunctivitis	• Persons presenting with an eye complaint with: o Pus discharge from eye/s o Irritation and redness of the eye/s o Excessive lacrimation o Swelling of the orbit and conjunctiva o Photophobia o A recent Upper Respiratory Tract Infection	• Infective Conjunctivitis Treatment Protocol • Client Information Sheet – Conjunctivitis
Allergic conjunctivitis	• Persons presenting with an eye complaint with: o Itchiness/Irritation and redness of the eye/s o Excessive lacrimation o Swelling of the orbit and conjunctiva o Photophobia	• Allergic Conjunctivitis Treatment Protocol • Client Information Sheet – Conjunctivitis

Dry eye syndrome	• Persons presenting with an eye complaint • Client complaining of pain similar to that of an ocular foreign body but no history of same, and of long duration. • Minimal lubrication of the eye noted on examination • Corneal irritation may be present	• Dry Eye Syndrome Treatment Protocol • Client Information Sheet – Dry Eye Syndrome
Non invasive foreign body of the eye	• Persons presenting with an eye complaint • On examination a foreign body is identified on the corneal surface of the eye or eyelid that is easily removable	• Foreign Body Eye Treatment Protocol
Single red eye	• Persons presenting with a single, red eye, complaining of pain and or irritation • **Exclude infective/allergic conjunctivitis**	• Redirect to ED Protocol
Corneal Abrasion or Ulceration	• Identified uptake on fluorescein application	• Requires consultation with Opthalmology Team regarding required treatment and referral process

References:

- National Health Service Institute for Innovation and Improvement: Clinical Knowledge Summaries

Infective Conjunctivitis Treatment Protocol

Treatment

- Visual acuity should be assessed on all clients presenting with an eye complaint
- Visual acuity assessment:
  1. Visual acuity should be assessed in a well lit environment
  2. The procedure should be explained to the client
  3. The client should be positioned at the correct distance from the chart (Indicated on the chart, commonly 6 metres)
  4. Covering one eye (The non-affected eye should be tested first) the client should be asked to read the lowest line of letters they can see clearly (The client needs to get 3 of the 5 letters correct for that line to be accepted)
  5. Step 4 should be repeated with the alternate eye
  6. The results should be documented as a fraction eg R6/7.5 L6/6, (Distance from the chart / Size of the symbols read)
- Evert the upper eyelid and examine for follicles and papillae prior to the management of infective conjunctivitis
- The cornea should be examined for abrasions using flourescein strip prior to the management of infective conjunctivitis
- Antibiotic solutions should be used to manage the symptoms of infective conjunctivitis

Advice

- While Adenovirus is commonly associated with conjunctivitis, differentiating between a viral or bacterial cause for conjunctivitis is very difficult thus empirical antibiotic therapy is indicated
- Clients should be advised to wash away the discharge from their eyes regularly with warm water, using a new tissue to dry each eye
- To reduce the incidence of cross-transmission, commonly high with infective conjunctivitis, the client should be advised to take great care when washing their hands regularly and not touching their eyes
- Children should remain absent from school and childcare during the infective period
- Client Information Sheet – Conjunctivitis

Medication Standing Orders

- Chloramphenicol

References	
• National Health Service Institute for Innovation and Improvement: Clinical Knowledge Summaries 2009	• Therapeutic Guidelines, 2009 • Australian Medicines Handbook, 2009
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ACT Government
Health

Walk-in Centre Information Sheet

Infective Conjunctivitis

Expected Length of Illness

- The symptoms associated with conjunctivitis should resolve within 2-5 days

Expected Symptoms

- Irritation and redness of the eye/s
- Crusting on the eyelids
- Excessive tears from the eyes
- A yellow/green discharge
- Swelling of the eyelids and outer part of the eye

Common Management of Symptoms

- Antibiotic eye drops or ointment are effective in the management of infective conjunctivitis
- It is important that you wash away the discharge from the eyes regularly with warm water, using a new tissue to dry each eye
- Conjunctivitis is infectious during the period that discharge is coming from around the eyes. Great care, such as washing your hands regularly and not touching your eyes, should be taken to avoid infecting others
- Children should remain absent from school and childcare during the infective period

Common Medications

- Antibiotic eye drops or ointment are commonly used in the management of infective conjunctivitis
- These medications are available without a script at your chemist

When to Seek Further Advice

- If you are worried call healthdirect on 1800 022 222
- If your symptoms do not improve you should see your General Practitioner
- You should seek urgent medical attention at the Emergency Department or by dialling 000 if you are very unwell

March 2014

Allergic Conjunctivitis Treatment Protocol

Treatment

- Visual acuity should be assessed on all clients presenting with an eye complaint
- Visual acuity assessment
  1. Visual acuity should be assessed in a well lit environment
  2. The procedure should be explained to the client
  3. The client should be positioned at the correct distance from the chart (Indicated on the chart, commonly 6 metres)
  4. Covering one eye (The non-affected eye should be tested first) the client should be asked to read the lowest line of letters they can see clearly (The client needs to get 3 of the 5 letters correct for that line to be accepted)
  5. Step 4 should be repeated with the alternate eye
  6. The results should be documented as a fraction e.g. R6/7.5 L6/6, (Distance from the chart / Size of the symbols read)
- Identify triggers for the allergic conjunctival reaction (e.g. pollens, house dust mites, cosmetics, ophthalmic drugs, contact lenses and solutions)
- Evert the upper eyelid and examine for follicles and papillae prior to the management allergic conjunctivitis
- The cornea should be examined for abrasions using flourescein strip prior to the management of allergic conjunctivitis
- Artificial tear and/or antihistamine solutions should be used to manage the symptoms of allergic conjunctivitis

Advice

- The client should be advised to avoid irritants such as pollens, house dust mites, cosmetics, dust or chemical exposure
- Client Information Sheet –Allergic Conjunctivitis

Medication Standing Orders

- Albalon - A

References

- National Health Service Institute for Innovation and Improvement: Clinical Knowledge Summaries 2009
- Therapeutic Guidelines, 2009
- Australian Medicines Handbook, 2009

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Walk-in Centre Information Sheet

Allergic Conjunctivitis

Expected Length of Illness

- The symptoms associated with conjunctivitis should resolve within 2 days to 3 weeks

Expected Symptoms

- Irritation and redness/pinkness of the eye/s
- Excessive tears from the eyes
- Swelling of the eyelids and outer part of the eye

Common Management of Symptoms

- The most important management of allergic conjunctivitis is to avoid factors that lead to the eye irritation. If the eyes are affected, they should be washed gently with clean water
- Antihistamine eye drops reduce the symptoms of allergic conjunctivitis
- Allergic conjunctivitis is not infectious and there is no need to take any time off work, school or childcare
- It is important that you wash away the discharge from the eyes regularly with warm water, using a new tissue to dry each eye.

Common Medications

- Artificial tears or antihistamine eye drops are commonly used in the management of allergic conjunctivitis
- These medications are available without a script at your chemist

When to Seek Further Advice

- If you are worried call healthdirect on 1800 022 222
- If your symptoms do not improve you should see your General Practitioner
- You should seek urgent medical attention at the Emergency Department or by dialling 000 if you are very unwell

March 2014

Dry Eye Syndrome Treatment Protocol

Treatment

- Visual acuity should be assessed on all clients presenting with an eye complaint
- Visual acuity assessment
    1. Visual acuity should be assessed in a well lit environment
    2. The procedure should be explained to the client
    3. The client should be positioned at the correct distance from the chart (Indicated on the chart, commonly 6 metres)
    4. Covering one eye (The non-affected eye should be tested first) the client should be asked to read the lowest line of letters they can see clearly (The client needs to get 3 of the 5 letters correct for that line to be accepted)
    5. Step 4 should be repeated with the alternate eye
    6. The results should be documented as a fraction eg R6/7.5 L6/6, (Distance from the chart / Size of the symbols read)
- Evert the upper eyelid and examine for follicles and papillae prior to the management of dry eye syndrome
- The cornea should be examined for abrasions using flourescein strip
- Artificial tear solutions should be used to manage the symptoms of dry eye

Advice

- Dry eye is a chronic condition that may be a symptom of an underlying more complex condition. All clients with dry eye should be referred to their GP once treatment has been initiated at the WiC
- Clients taking medications or who have concurrent general health conditions should be referred to discuss their dry eye syndrome with their GP
- The client should be advised to avoid dry eye irritants such as dry windy conditions, air-conditioned environments, cigarette smoke, dust or chemical exposure
- When outdoors the client should be encouraged to wear sunglasses to reduce the impact of wind and sun worsening the symptoms of dry eye
- When in a room for an extended period of time the client should be encouraged to raise the humidity level of the room, to reduce the symptoms of dry eye syndrome
- Client Information Sheet – Dry Eye Syndrome

Medication Standing Orders

- Artificial Tears

References

- National Health Service Institute for Innovation and Improvement: Clinical Knowledge Summaries 2009
- Therapeutic Guidelines, 2009
- Australian Medicines Handbook, 2009

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ACT Government
Health

Walk-in Centre Information Sheet

Dry Eye Syndrome

Expected Length of Illness

- The symptoms associated with dry eye syndrome are intermittent and should be relieved almost immediately with the use of artificial tears
- Dry eye is a chronic condition that is best treated by your GP

Expected Symptoms

- Stinging, burning and itchiness
- Occasional blurred vision
- Redness and a feeling of tired eyes
- Mucous around the eyelids, particularly upon waking
- A sensation of having sand in the eye

Common Management of Symptoms

- Dry eye syndrome can affect anyone at any age, though is more common in the elderly, postmenopausal women and people with arthritis
- Some medications and general health conditions may make dry eye worse. Dry eye can be a symptom of a serious illness, you should discuss these issues with your GP
- The most effective management of dry eye syndrome is based on avoiding irritants such as: dry windy conditions, air-conditioned environments, cigarette smoke, dust or chemical exposure
- Wearing sunglasses when outdoors may reduce the impact of wind and sun worsening the symptoms of dry eye
- Raising the humidity level of the room you are in will also help reduce the symptoms of dry eye syndrome
- Using artificial tear solutions or specialised gels are the most common way that you can manage the symptoms of dry eye

Common Medications

- Artificial tears are commonly used in the management of dry eye syndrome
- This medication is available without a script at your chemist

When to Seek Further Advice

- If you are worried call healthdirect on 1800 022 222
- If your symptoms do not improve you should see your General Practitioner
- You should seek urgent medical attention at the Emergency Department or by dialling 000 if you are very unwell

March 2014

Foreign Body Eye Treatment Protocol

Treatment

- Visual acuity should be assessed on all clients presenting with an eye complaint
- Visual acuity assessment
  1. Visual acuity should be assessed in a well lit environment
  2. The procedure should be explained to the client
  3. The client should be positioned at the correct distance from the chart (Indicated on the chart, commonly 6 metres)
  4. Covering one eye (The non-affected eye should be tested first) the client should be asked to read the lowest line of letters they can see clearly (The client needs to get 3 of the 5 letters correct for that line to be accepted)
  5. Step 4 should be repeated with the alternate eye
  6. The results should be documented as a fraction eg R6/7.5 L6/6, (Distance from the chart / Size of the symbols read)
- Evert the upper eyelid and examine for follicles and papillae
- The cornea should be examined for abrasions using flourescein strip prior to any management
- Artificial tear solutions or normal saline should be used to irrigate the affected eye to remove any foreign bodies

Advice

- Persons with a foreign body to the eye with a visual deficit should be redirected to the ED
- Persons with a foreign body to the eye that is complicated or not easily removed should be redirected to the ED
- Persons with a metal foreign body to the eye should be redirected to the ED
- The client should be advised to avoid irritant conditions such as dry windy conditions or grinding without eye protection

Medication Standing Orders

- Artificial Tears

References

- National Health Service Institute for Innovation and Improvement: Clinical Knowledge Summaries 2009
- Therapeutic Guidelines, 2009
- Australian Medicines Handbook, 2009

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Clinical Impressions:

Fever

Condition	Criteria	Treatment
High risk fever illness	• Persons presenting with a complaint of fever • Signs and symptoms: o Pale / mottle / ashen / blue o Responds only to pain or is unresponsive o Respiratory distress o Tachypnoea with accessory respiratory muscle use o Reduced skin turgor o Non-blanching rash with or without neck stiffness o Seizures or history of convulsions o Vomiting bile stained fluid	• Call Ambulance
Intermediate risk fever illness	• Persons presenting with a complaint of fever • No high risk signs or symptoms • Signs and symptoms o Pallor o Responds to voice o Tachypnoea and/or decreased oxygen saturation o Dry mucous membranes o Reduced urine output o Fever for ≥ 5 days	• Redirect to ED Protocol

Low risk fever illness	• Persons presenting with a complaint of fever
	• No intermediate or high risk signs or symptoms
	• Signs and symptoms
	  ○ Normal skin colour
	  ○ Alert
	  ○ Normal respiratory functioning
	  ○ Normal skin turgor
		• Fever Treatment Protocol
		• Client Information Sheet – Fever

References:

- National Health Service Institute for Innovation and Improvement: Clinical Knowledge Summaries
- National Collaborating Centre for Women's and Children's Health – Clinical Guideline May 2007

Fever Treatment Protocol

Treatment

- Anti-pyretics should be used to minimise the symptoms associated with a fever illness

Advice

- Fever is a symptom. A cause for the fever should be sought and the client referred as appropriate
- Avoid conditions that lead to shivering
- Persons with a fever illness should not be placed on prophylactic antibiotics
- Increase fluid intake
- Encourage the client to rest while suffering from a fever illness
- Utilise the cooling effects of evaporation by placing a fan in the room and wiping exposed skin with a damp cloth (avoid the extremities to prevent hypothermia)
- Ensure that the client is aware when they should seek further assessment regarding their fever illness, as described on the client information sheet
    - You should seek urgent medical attention if you develop a rash or neck stiffness, difficulty breathing, become confused, your temperature goes above 40°C, you stop sweating or become very unwell
- Client Information Sheet – Fever

Medication Standing Orders

- Paracetamol
- Ibuprofen

References

- National Health Service Institute for Innovation and Improvement: Clinical Knowledge Summaries 2009
- Therapeutic Guidelines, 2009
- Australian Medicines Handbook, 2009

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ACT Government
Health

Walk-in Centre Information Sheet

Fever

Expected Length of Illness

- The common fever illness has a rapid onset, with symptoms commonly lasting 3 days

Expected Symptoms

- Feeling unwell and tired
- Hot and sweaty feeling not related to the weather
- Shivering
- Flushed face

Common Management of Symptoms

- Comfort measures and rest are the most appropriate management
- Extra fluid should be drunk during the course of the illness to balance for the excess water lost through sweating.
- Extra rest is also advised, but normal activity will not make the illness last longer
- Taking medications may help to bring down the temperature and reduce the symptoms associated with a fever
- Wiping the back and stomach with a wet cloth or sponge will boost the cooling effect of evaporation
- Avoid taking cold baths or showers as the cold may cause shivering, which can generate more heat

Common Medications

- Paracetamol or Ibuprofen may relieve the symptoms of fever
- These medications are available without a script at your chemist

When to Seek Further Advice

- If you are worried call healthdirect on 1800 022 222
- If your symptoms do not improve you should see your General Practitioner
- You should seek urgent medical attention at the Emergency Department or by dialling 000 if you are very unwell

March 2014

Clinical Impressions:

Genito-urinary Conditions

Condition	Criteria	Treatment
Menorrhagia	• Persons presenting with a complaint of menses pain • PV bleeding greater than normal menstrual blood loss (Six or more tampons per day for 4-5 days)	• Redirect to GP Protocol
Primary dysmenorrhoea	• Persons presenting with a complaint of menses pain • No pathological underlying cause	• Primary dysmenorrhoea Treatment Protocol • Client Information Sheet – Period Pain
Secondary dysmenorrhoea	• Persons presenting with a complaint of menses pain • On examination and history the client identifies a pathological underlying cause such as endometriosis or pelvic inflammatory disease (PID)	• Redirect to GP Protocol
Pregnancy with PV discharge/bleeding	• Persons presenting with a complaint of vaginal discharge during pregnancy	• Redirect to ED Protocol
Pregnancy with abdominal pain	• Persons presenting with a complaint of abdominal pain during pregnancy	• Redirect to ED Protocol

Pregnancy	• Persons presenting with a query as to the possibility of pregnancy • Emergency contraception is not being requested	• Pregnancy Test Treatment Protocol • Provide the leaflet 'Having your baby in the ACT' - ACT Health
Sexually Transmitted Infection (STI)	• Persons presenting with abnormal genital symptoms • On assessment the client's history is suggestive of a possible STI	• Redirect to Sexual Health
Bacterial vaginosis	• Persons presenting with candidiasis-like symptoms (Thrush) • Malodorous vaginal discharge • Commonly, clients suffering bacterial vaginosis are asymptomatic	• Redirect to Sexual Health
Vulvovaginal candidiasis	• Persons presenting with candidiasis-like symptoms: o Vaginal discomfort (Itching / burning) o White vaginal discharge o Redness and / or swelling of the vagina or vulva o Stinging and / or burning when urinating or during sex o Splits in the genital skin	• Vulvovaginal Candidiasis Treatment Protocol • Client Information Sheet – Vaginal Thrush
Recurrent or resistant Urinary Tract Infection	• Persons presenting with a complaint of UTI symptoms or with risk of diabetes, Inmmunosuppressed, IDC, abnormal anatomy, and/or pregnant • Persons who have taken a complete course of antibiotics without the resultant cessation of UTI symptoms • Persons that have had 3 or more confirmed diagnosis's of UTI in the past 12 months	• Redirect to GP Protocol

Prostatitis	• Male persons presenting with a complaint of urinary tract infection (UTI) symptoms • Painful ejaculation • Lower back and perineal pain • Fever and chills • Muscular pain	• Redirect to GP Protocol

Pyelonephritis	• Persons presenting with a complaint of urinary tract infection (UTI) symptoms
	  ○ Dysuria
	  ○ Urgency
	• Lower back and / or flank pain
	• Fever and chills
	• Muscular pain
		• Redirect to ED Protocol

Cystitis	• Persons presenting with a complaint of urinary tract infection (UTI) symptoms
	• May present with haematuria and pain above the pubic bone
	• Excluding:
	  ○ Persons < 16 years old
	  ○ Males
	  ○ Pregnant women
	  ○ Persons with an indwelling urethral catheter (IDC) or suprapubic catheter (SPC)
		• Lower UTI Treatment Protocol
		• Client Information Sheet – Lower Urinary Tract Infection

Urethritis	• Persons presenting with a complaint of urinary tract infection (UTI) symptoms
	• Consider STI
	• Usually uncomplicated
	• Excluding:
	  ○ Persons < 16 years old
	  ○ Males
	  ○ Pregnant women
		• Lower UTI Treatment Protocol
		• Client Information Sheet – Lower Urinary Tract Infection
		• If UTI not identified consider redirection to Sexual Health Clinic

	○ Persons with an IDC or SPC	
UTI in a child	• Child presenting with a complaint of UTI symptoms • Age < 16 years of age due to the risk of urethral scarring	• Redirect to GP Protocol

References: National Health Service Institute for Innovation and Improvement: Clinical Knowledge Summaries

Primary Dysmenorrhoea Treatment Protocol	
Treatment	
• NSAIDs should be recommended for the management of primary dysmenorrhoea, period pain	
Advice	
• Persons with contraindications of gastrointestinal complications secondary to the use of NSAIDs should be started on Paracetamol and referred to the GP for further management • The client should be advised to cease or reduce smoking to aid in minimising the affects of period pain • Heat therapy to the lower abdomen and back has been found to minimise uterine muscle cramping pain • If period pain is a common condition, NSAID therapy should be initiated 1-2 days prior to the menses • If period pain is a chronic condition, the client should be referred to their GP for possible hormonal management • Hydration and female (menses) specific diet considerations should be discussed, eg higher iron and calcium diets • Client Information Sheet – Period Pain	
Medication Standing Orders	
• Paracetamol • Ibuprofen	
References	
• National Health Service Institute for Innovation and Improvement: Clinical Knowledge Summaries 2009	• Therapeutic Guidelines, 2009 • Australian Medicines Handbook, 2009 • Young Adult Health, SA Health
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ACT Government
Health

Walk-in Centre Information Sheet

Period pain

Expected Length of Symptoms

- The symptoms associated with period pain normally last 5 days

Expected Symptoms

- Feeling of being bloated or heavy
- Vaginal bleeding
- Cramping pain of the lower abdomen, lower back and sometimes in the legs
- Tenderness of the breasts

Common Management of Symptoms

- Period pain is mostly due to the contraction of the uterus muscles
- Period pain is very common and generally does not indicate anything is wrong within your body
- Women who smoke are at the greatest risk of experiencing period pain and having premenstrual tension
- Heat packs on the lower abdomen and light exercise can reduce the symptoms associated with period pain
- Many of the medications used to reduce the symptoms of period pain work best if they are begun a day or two before your period

Common Medications

- Ibuprofen, Diclofenac and Mefenamic Acid, are commonly used in the management of period pain
- Paracetamol may also aid in the relief of symptoms
- All of these medications are available without a script at your chemist

When to Seek Further Advice

- If you are worried call healthdirect on 1800 022 222
- If your symptoms do not improve you should see your General Practitioner
- You should seek urgent medical attention at the Emergency Department or by dialling 000 if you are very unwell

March 2014

Pregnancy Test Treatment Protocol

Treatment

- Pregnancy should be confirmed through client examination, history collection and urine HCG
- Ascertain LMP and date of last unprotected sexual intercourse. Urine pregnancy test is not effective until 7 -11 days after conception.
- The possibility of STIs should be considered
- All persons confirmed pregnant should be referred back to their GP/SHFPACT for further antenatal advice
- Document gravida and parity (e.g. G2 P1)

Advice

- Antenatal health care may be provided by midwives, GPs or obstetricians, either in the private or public sectors
- The first antenatal appointment should be made with the woman's primary antenatal care provider as soon as possible
- It is common for pregnant women to take nutritional supplements, especially during the first trimester to minimize the incidence of deformities, such as the use of folic acid to minimise neural tube deformities
- The client should be advised on termination options if that is a choice of action indicated by the client. Sexual Health & Family Planning, ACT are able to provide further services and advice in this area
- Client Information Sheet – 'Having your baby in the ACT' - ACT Health

Medication Standing Orders

- N/A

References

- National Health Service Institute for Innovation and Improvement: Clinical Knowledge Summaries 2009
- Therapeutic Guidelines, 2009
- Australian Medicines Handbook, 2009

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Vulvovaginal Candidiasis Treatment Protocol

Treatment

- Vulvovaginal candidiasis overgrowth should be managed via the application of an Imidazole intravaginal preparation from the chemist

Advice

- Thrush, vulvovaginal candidiasis, is very common (80% of women will experience an episode of thrush), and is due to an overgrowth of the normal yeast found in the vagina known as candida albicans
- Pregnancy should be ruled out prior to the management of vulvovaginal candidiasis. If the client is pregnant they should be referred to their GP
- Thrush is not an STI. If it is suspected that the client may have a STI they should be redirected to Sexual Health and Family Planning ACT, Canberra Sexual Health or their GP
- A thorough history should be obtained from the client to identify recurrent or complicated thrush (constant symptoms or more than 4 episodes per year)
- Clients with complicated vulvovaginal candidiasis, such as recurrent vulvovaginal candidiasis, who are immunosuppressed or have diabetes should be managed by their GP
- Some intravaginal preparations for the management of vulvovaginal candidiasis may themselves cause irritation
- The client should minimise their exposure to non pH balanced soap products, both personal and laundry types
- Perfumes should not be used in the perineal area
- Females should be advised to wipe from front to back to prevent faecal contamination of the vagina
- Antibiotic therapy is a common cause of thrush and women undergoing a course of antibiotics should be encouraged to take a pro-biotic supplement
- Client Information Sheet – Vaginal Thrush

Medication Standing Orders

- N/A

References

- National Health Service Institute for Innovation and Improvement: Clinical Knowledge Summaries 2009
- Therapeutic Guidelines, 2009
- Australian Medicines Handbook, 2009
- Young Adult Health, SA Health

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ACT Government Health

Walk-in Centre Information Sheet

Vaginal Thrush

Expected Length of Condition

- The symptoms associated with thrush normally last up to 7 days once treatment has begun

Expected Symptoms

- Vaginal discomfort
- Itching or burning
- A white vaginal discharge
- Redness and / or swelling of the vagina or vulva
- Stinging and / or burning when urinating or during sex

Common Management of Symptoms

- Thrush is not a sexually transmitted disease. It is an overgrowth of the yeast that normally lives in the vagina
- The bottom should be wiped from front to back to prevent faecal contamination of the vagina. Douches and the use of antiseptic wash solutions should also be avoided
- Wearing dry natural material underwear such as cotton may reduce symptoms
- Thrush symptoms may be managed with a vaginal cream or an oral medication. You should discuss medication options with your Pharmacist

Common Medications

- Clotrimazole, Nystatin and Fluconazole, are commonly used in the management of vaginal thrush
- These medications are available without a script at your chemist

When to Seek Further Advice

- If you are worried call healthdirect on 1800 022 222
- If your symptoms do not improve you should see your General Practitioner
- You should seek urgent medical attention at the Emergency Department or by dialling 000 if you are very unwell

March 2014

Lower Urinary Tract Infection Treatment Protocol

Treatment

- A urinary tract infection (UTI) should be confirmed by client assessment displaying the symptoms of an uncomplicated UTI:
  - Dysuria
  - Urgency
  - Frequency
- Where there are symptoms of a UTI the diagnosis may be supported by a urinalysis displaying all of the following:
  - Leukocytes
  - Nitrites
  - Blood
- Administration of antibiotics as per the standing order

Advice

- Increased fluid intake
- Recommend post coital urination
- Prophylactic use of Cranberry products may reduce the incidence of UTIs
- Client Information Sheet – Urinary tract infection

Medication Standing Orders

- Trimethoprim
- Cephalexin
- Paracetamol
- Ibuprofen

References

- National Health Service Institute for Innovation and Improvement: Clinical Knowledge Summaries 2009
- Therapeutic Guidelines, 2009
- Australian Medicines Handbook, 2009

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ACT Government
Health

Walk-in Centre Information Sheet

Lower Urinary Tract Infection (Non Pregnant Women)

Expected Length of Illness

- The symptoms associated with a urinary tract infection normally last 3-14 days
- Symptoms resolve within 3–5 days of treatment

Expected Symptoms

- Pain when passing urine
- Urgency (The feeling of needing to pass urine)
- Frequency (Passing urine regularly)

Common Management of Symptoms

- To assist the body in flushing the urinary system it is important to increase the amount of fluids that you are drinking during the illness
- In some cases antibiotics may be required. If you are prescribed antibiotics it is important to finish them, even if you are feeling better
- Urinary alkalinisers may help to relieve pain on urination
- To prevent future urinary tract infections, it is important to drink regularly and urinate without delay when the need is felt
- When wiping the bottom, wipe front to back to avoid urinary tract infections
- To reduce the possibility of a urinary tract infection, women should urinate after sex

Common Medications

- Ibuprofen and Paracetamol/urinary alkalisers may aid in the relief of symptoms
- These medications are available without a script at your chemist
- In some cases antibiotics may be required

When to Seek Further Advice

- If you are worried call healthdirect on 1800 022 222
- If your symptoms do not improve you should see your General Practitioner
- You should seek urgent medical attention at the Emergency Department or by dialling 000 if you are very unwell

March 2014

Clinical Impressions:

Headache

Condition	Criteria	Treatment
Headache post head trauma	• Persons presenting with a complaint of headache post head injury	• Redirect to ED Protocol
Vomiting associated with headache	• Persons presenting with a complaint of headache with concurrent vomiting	• Redirect to ED Protocol
Changes in consciousness associated with headache	• Persons presenting with a complaint of a headache with concurrent changes in their level of consciousness	• Redirection via ambulance call 0 000 • Redirect to ED Protocol
Headache with sudden onset	• Persons presenting with a complaint of a sudden onset headache	• Redirect to ED Protocol
Headache with associated fever	• Persons presenting with a complaint of headache with concurrent fever or signs of sepsis, rash or neck stiffness	• Redirection via ambulance call 0 000 • Redirect to ED Protocol
Tension headache	• Persons presenting with a complaint of headache • Recurrent attacks of headaches that are usually bilateral • Feeling of heaviness, pressure or tightness that may extend like a band around the head • There may be photophobia, but nausea and vomiting are unusual • Rarely severe enough to prevent activity such as walking or climbing stairs	• Headache Treatment Protocol • Client Information Sheet – Headache

Migraine	• Recurrent episodes of throbbing head pain, which are often unilateral (frontal, occipital or hemi cranial) and may swap sides between attacks • May present with or without a visual aura • Pain is severe and limits or stops activity, and is usually associated with nausea, vomiting and/or photophobia	• Migraine Treatment Protocol • Client Information Sheet – Migraine Headaches
Cluster headache	• Attacks are usually centred around the orbit, with prominent autonomic symptoms (ptosis, tearing and redness of the eye, nasal stuffiness) the headache does not swap sides between attacks • Multiple attacks each day for weeks or months, often occurring predictably at the same time each day	• Headache Treatment Protocol • Client Information Sheet – Headache
Ice-pick headache	• Sudden stabbing pains, often bilateral, typically lasting a few seconds, often very severe and can occur unpredictably 30 or more times per day	• Headache Treatment Protocol • Client Information Sheet – Headache
Exertional headache	• Brief attacks of headache precipitated by coughing, sneezing, straining, exertion or bending over (distinguished from pre-existing headache that is momentarily aggravated by exertion)	• Redirect to ED Protocol
Postural headache	• Headache that resolves rapidly on lying down	• Redirect to GP Protocol
Chronic headache	• Unremitting headache (occurring on 4 or more days per week); often a mix of migraine and tension headache symptoms	• Redirect to GP Protocol

Headache originating from neck, jaw or shoulder	• Client reports that neck, jaw or shoulder pain associated with their headache • Exacerbation of head pain when neck range of movement is assessed	• Redirect to GP Protocol

References:

- National Health Service Institute for Innovation and Improvement: Clinical Knowledge Summaries
- Therapeutic Guidelines, 2009

Headache Treatment Protocol	
Treatment	
• All persons presenting with a complaint of a headache should be thoroughly assessed both physically and via an extensive history to minimise the risk of an undiagnosed complicated headache • The primary management of an uncomplicated, gradual onset headache, should be based around the identification and minimisation of trigger factors associated with the clients headache • Simple analgesia should be administered to aid in the resolution of the uncomplicated headache and positive effect of the pharmacological management noted prior to leaving, usually 30 minutes	
Advice	
• Positive life style changes including diet and hydration should be discussed • The client should be assisted with the identification of trigger factors associated with their headache and exposure minimisation strategies advised • Client Information Sheet – Headache	
Medication Standing Orders	
• Paracetamol • Ibuprofen	
References	
• National Health Service Institute for Innovation and Improvement: Clinical Knowledge Summaries 2009 • Therapeutic Guidelines, 2009 • Australian Medicines Handbook, 2009	
Approval	
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ACT Government
Health

Walk-in Centre Information Sheet

Headache

Expected Length of Illness

- An uncomplicated headache with a gradual onset will usually last 15 minutes – 6 hours

Expected Symptoms

- Tension headaches
  - Feeling of heaviness or tightness like a band around the head
  - Rarely bad enough to prevent activity such as walking
- Cluster headaches
  - Attacks are usually focused around one of the eyes and nose
  - May come and go during the day, at the same time each day
- Ice-pick headaches
  - Sudden stabbing pains throughout the head, typically lasting a few seconds and very painful
  - May come and go unpredictably many times per day

Common Management of Symptoms

- Most headaches are due to stress and / or muscle tension, though some may be due to external causes such as noise or diet
- As headaches are generally a symptom of an external stressor the most effective way to manage the symptoms of a headache is to identify the cause and avoid or remove yourself from those environments
- Many people find that having something to eat and drink then moving to a quiet place to rest will ease or resolve the symptoms of a headache
- Most symptoms resolve completely after removing yourself from the stressful environment or taking medications
- There are many causes of a headache, some of which are serious health concerns. If your headache doesn't respond to treatment you should seek advice from your GP

Common Medications

- Paracetamol or Ibuprofen may relieve the symptoms of a headache
- These medications are available from your pharmacy

When to Seek Further Advice

- If you are worried call healthdirect on 1800 022 222
- If your symptoms do not improve you should see your General Practitioner
- You should seek urgent medical attention at the Emergency Department or by dialling 000 if you are very unwell

March 2014

Migraine Treatment Protocol	
Treatment	
• All persons presenting with a complaint of a headache should be thoroughly assessed both physically and via an extensive history to minimise the risk of an undiagnosed complicated migraine • The primary management of an uncomplicated, gradual onset migraine headache, should be based around the identification and minimisation of trigger factors associated with the clients migraine • Analgesia and anti-emetics should be administered to aid in the resolution of the uncomplicated migraine headache and positive affect of the pharmacological management noted prior to discharge	
Advice	
• As migraines are a chronic condition the client should be advised to see their GP for the management of symptoms and attacks • Client Information Sheet – Migraine Headaches	
Medication Standing Orders	
• Paracetamol • Ibuprofen • Metoclopramide	
References	
• National Health Service Institute for Innovation and Improvement: Clinical Knowledge Summaries 2009 • Therapeutic Guidelines, 2009 • Australian Medicines Handbook, 2009	
Approval	
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ACT Government
Health

Walk-in Centre Information Sheet

Migraine Headache

Expected Length of Illness

- An uncomplicated migraine headache with a gradual onset will usually last 15 minutes – 6 hours. Untreated migraines may last up to 3 days

Expected Symptoms

- Nausea and vomiting
- Sensitivity to light and sound
- Affected vision such as, flickering lights, zig-zag lines, loss of part or all vision
- Sensitivity to smell and touch

Common Management of Symptoms

- This condition is commonly triggered by factors such as diet, sleep, emotional changes, stress, excessive environmental conditions or a woman's menstrual cycle
- Many people find that moving to a dark place to rest will ease or resolve the symptoms of a migraine headache
- Most symptoms resolve completely after removing yourself from the stressful environment and taking medications. Migraines generally do not resolve in a short amount of time
- There are many causes of a headache, some of which are serious health concerns. If your migraine headache doesn't respond to the medications you normally take, you should seek advice from your GP
- Due to the debilitating effects of a migraine and the side effects of the medications used to manage a migraine, you should not drive or operate machinery

Common Medications

- Paracetamol, Aspirin or Ibuprofen may relieve the symptoms of a migraine headache. These medications are available without a script at your chemist
- When nausea and vomiting are involved a medication such as Metoclopramide or Prochlorperazine may be used.

When to Seek Further Advice

- If you are worried call healthdirect on 1800 022 222
- If your symptoms do not improve you should see your General Practitioner
- You should seek urgent medical attention at the Emergency Department or by dialling 000 if you are very unwell

March 2014

Clinical Impressions:

Mental Health

Condition	Criteria	Treatment
Self harm	• Persons presenting with an intent of self harm • Persons presenting with actual self harm, limited to superficial lacerations	• Contact Crisis Assessment and Treatment Team (CATT) Protocol • Laceration Treatment Protocol • Client Information Sheet – Cuts and Grazes • Safety and Security Policy
Threat to persons or property	• Persons presenting as a threat to other persons or property	• Redirect to ED Protocol • Contact ACT police ring 0 000 • Safety and Security Policy
Suicidal	• Persons presenting with suicidal ideation	• Redirect to ED Protocol • Contact Crisis Assessment and Treatment Team (CATT) Protocol • Safety and Security Policy
Acute Anxiety	• Person presenting displaying signs and symptoms of anxiety: o Palpitations o Sweating and trembling o Tachypnoea o Nausea o Dizziness, or faintness o Numbness, or pins and needles o Feelings of unreality, or being detached from yourself	• Refer to GP • Safety and Security Policy

Depression	• Person presenting displaying signs and symptoms of depression: o Depressed mood o Overly self-critical o Lethargy o Nauseous o Loss of appetite or over-eating o Changes in sleep patterns o Headaches and / or stomach aches	• Redirect to CATT Protocol if thoughts of self harm/suicide • Safety and Security Policy
Psychosis	• Person presenting displaying signs and symptoms of psychosis state: o Delusional o Hallucinations o Erratic behaviour o Erratic emotional responses	• Redirect to ED Protocol • Contact ACT police 0 000 • Safety and Security Policy

References: National Health Service Institute for Innovation and Improvement: Clinical Knowledge Summaries

Clinical Impressions:

Sexual Health

Condition	Criteria	Treatment
Emergency contraception	• Unprotected sexual intercourse within the last 120 hours	• Emergency Contraception Treatment Protocol • Emergency Contraception leaflet: Sexual Health & Family Planning, ACT (SHFPACT)
Suspected sexually transmitted infection (STI)	• Client sexually active, presenting with Genito-urinary symptoms, suggestive of an STI	• Redirect to Canberra Sexual Health Clinic Protocol
Sexual assault	• Client reports sexual assault	• Forensic and Medical Sexual Assault Care (FAMSAC) 6244 2184
Safe sex advice	• Client concerned re STI prevention	• Safe Sex Advice Treatment Protocol • Enjoy Sex Safely leaflet (SHFPACT)
Contraceptive advice	• Client requesting advice re contraception	• Contraceptive Advice leaflet (SHFPACT)

Pregnancy	• Positive pregnancy test	• Pregnancy Treatment Protocol • 'Options' advice leaflet: SHFPACT • 'Having a baby in the ACT'

References: National Health Service Institute for Innovation and Improvement: Clinical Knowledge Summaries

Emergency Contraception Protocol

Treatment

- Oral contraceptive medications should be prescribed within 120 hours (5 days) of the unprotected intercourse
- Outside of the 120 hour window for emergency contraceptive management the client should be referred to Sexual Health and Family Planning ACT (SHFPACT), Canberra Sexual Health Clinic or their GP WHY
- A referral to the Canberra Sexual Health Clinic, SHFPACT or the clients GP should be made regarding STI screening
- Provide condoms and lubricant as appropriate

Advice

- Emergency contraception is most effective if taken within 24 hours post coitus, is effective within 72 hours and may be effective out to 120 hours
- Advise the client of their options regarding emergency contraception
  - Walk-in Centre
  - 'The Junction' youth service
  - Sexual Health and Family Planning ACT
  - The client's GP
  - Community Pharmacy
- Give the SHFPACT leaflet 'Emergency Contraception'
- Inform the client that the emergency contraception may have side effects, commonly nausea and PV bleeding
  - If the client vomits within 2 hours of taking the emergency contraception another dose should be prescribed
  - Metoclopramide may only be used if the client presents with a history of vomiting post administration of the emergency contraception or have vomited within 2 hours of taking emergency contraception on this occasion
- Mandatory reporting must be complied with where applicable

Medication Standing Orders

- Levonorgestrel
- Metoclopramide

References	
• National Health Service Institute for Innovation and Improvement: Clinical Knowledge Summaries 2009	• Therapeutic Guidelines, 2009 • Australian Medicines Handbook, 2009
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Safe Sex Advice Treatment Protocol	
Treatment	
• Give and discuss SHFPACT 'Enjoying Sex Safely' leaflet • Give the client free condoms and lubricant • A referral to the Canberra Sexual Health Clinic, SHFPACT or the client's GP should be made, if there is a history of unprotected intercourse, for STI screening	
Advice	
• Redirect to SHFPACT or the own GP for further discussion or management • Condoms should always be promoted as they are the only form of contraception that protects from sexually transmitted infections	
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Contraceptive Advice Treatment Protocol	
Treatment	
• Give and discuss the SHFPACT 'Your contraception options' leaflet • Give the client free condoms and lubricant	
Advice	
• Redirect to SHFPACT or their own GP for further contraception management options • The Junction Youth Service provide free contraception for under 26 year olds • Different contraceptive methods suit different people and different practices, condoms should always be promoted as they are the only form of contraception that protects from sexually transmitted diseases and can be used with or without other methods • Advise that not all GP practices offer the Intra Uterine Device (IUD) or Implanon. Clients should contact the practice in advance in order to potentially save a wasted visit if service is not offered. • Advise the client that they may not be able to access certain types of contraception until they have excluded a pregnancy and an IUD would usually not be fitted on the first visit .	
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Pregnancy Options Treatment Protocol

Treatment

- Calculate the length of pregnancy e.g. Gestation ?/40 if known first day last period
- Document gravida (pregnancies) and parity (live births)(e.g. G2 P1)
- Discuss the client's thoughts regarding the positive pregnancy test
  - If the pregnancy is welcome news
    - Provide the client information sheet – Pregnancy
    - Advise them to see their GP
  - If the pregnancy is a shock or unwelcome
    - Provide the 'Options' SHFPACT leaflet
    - The client can be referred for pregnancy counseling through SHFPACT (this is a free service) or their GP,
    - If the client is under 26 then a pregnancy counseling service is available through 'The Junction' youth service

Advice

- Allow the client to discuss their thoughts and feelings regarding the pregnancy
- Do not advise the client on what actions they should take, instead inform them of their options
- If possible, or desired by the client, go through the information provided in the information sheets or leaflets
- Advise that there is support available whatever decision the client decides

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Clinical Impressions:

Wounds and Lacerations

Condition	Criteria	Treatment
Neurovascular compromise secondary to wound	• Persons presenting with a complaint of a dermal wound • Neurological deficit noted distal to the site of complaint • Vascular deficit noted distal to the site of complaint	• Redirect to ED Protocol
Uncontrolled haemorrhage	• Persons presenting with a complaint of a dermal wound • Bleeding is not controlled through methods of simple compression or single layer wound closure • On review the client has a bleeding disorder	• Redirect to ED Protocol
Amputation	• Persons presenting with a complaint of a dermal wound • Any form of limb or digit amputation noted on examination	• Redirect to ED Protocol
Foreign Body	• Persons presenting with a complaint of a dermal wound • On examination a foreign body is identified in the wound that is complicated or not able to be removed	• Medical Imaging Protocol • Redirect to ED Protocol
Stab wound	• Persons presenting with a complaint of a stab or penetrating injury • Depth of penetration is limited to the dermal and subcutaneous layers and not involving the head or torso	• Laceration Treatment Protocol • Client Information Sheet – Cuts and Grazes

Contusion	• Persons presenting with a complaint of a contusion • Complaint of bruising in subjacent tissues	• Contusion Treatment Protocol • Client Information Sheet – Bruising

	with tenderness on palpation	after Injury
Laceration	• Persons presenting with a complaint of a laceration injury • Irregular-edged wound with slight dehiscence • Wound depth not extending to the muscle fascia or requiring multiple layer closure	• Laceration Treatment Protocol • Client Information Sheet – Cuts and Grazes
Abrasion	• Persons presenting with a complaint of an abrasion • Superficial generalised erosion damage to the dermal layers of the skin from a mechanism of injury	• Abrasion Treatment Protocol • Client Information Sheet – Cuts and Grazes
Burns	• Persons presenting with a complaint of a burn or scald • Partial thickness (superficial) appear red and are commonly painful • Deep dermal (partial thickness) burns appear red with peeling and blistering of the skin • Full thickness burns appear black, grey or white with charring and have little or no pain.	• All full thickness burns to be redirected to the ED • Burn Treatment Protocol • Client Information Sheet – Burns
Ulcer	• Persons presenting with a complaint of an ulcerative type wound • Open wound resistant to healing, secondary to a pressure injury or vascular condition	• Redirect to GP Protocol • NP review
Cellulitis	• Persons presenting with a complaint of a skin infection • Infection of the subcutaneous tissue	• Redirect to ED Protocol • NP review

Laceration from a bite	• Persons presenting with a laceration post bite, from either animal, insect or human	• See Bite Protocol
Infected wound	• Persons presenting with a wound that is infected • Signs of redness around the wound with or without purulent discharge	• Redirect to GP Protocol • NP review
Suture Removal	• Persons presenting with a well approximated wound who have clear instructions for removal of sutures and who are unable to see a GP	• See Suture Removal Protocol
Wound Dressings	• Persons presenting with wounds that have been dressed elsewhere and are due for a dressing change in the absence of: o Complications o Wound infection o Plastic surgery	• See Wound Dressing protocol

References: National Health Service Institute for Innovation and Improvement: Clinical Knowledge Summaries