Policy Directive

The Use of the Emergency Care Assessment and Treatment (ECAT) Protocols

Summary To provide governance around the use of the Emergency Care Assessment and Treatment (ECAT) Protocols. This includes legislative requirements and prerequisite education and training.

Document type Policy Directive

Document number PD2023_039

Publication date 24 November 2023

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Review date 24 November 2028

Policy manual Not applicable

File number H23/83467

Status Active

Functional group Clinical/Patient Services - Critical Care, Imaging - diagnostic and interventional, Nursing and Midwifery, Pathology, Pharmaceutical
Corporate Administration - Governance
Personnel/Workforce - Learning and Development

Applies to Ministry of Health, Local Health Districts, Board Governed Statutory Health Corporations, Chief Executive Governed Statutory Health Corporations, Specialty Network Governed Statutory Health Corporations, Affiliated Health Organisations, Public Health System Support Division, Government Medical Officers, Public Hospitals

Distributed to Ministry of Health, Public Health System, Government Medical Officers

Audience Administration;Management;Clinical;Medical;Allied Health Staff;Nursing Staff;Emergency Department;Pathology Services;Pharmacy

Secretary, NSW Health

NSW Health

POLICY DIRECTIVE

The Use of Emergency Care Assessment and Treatment (ECAT) Protocols

POLICY STATEMENT

NSW Health is committed to supporting nurses to initiate emergency care according to their scope of practice, in accordance with the Emergency Care Assessment and Treatment (ECAT) Protocols and following the completion of prerequisite education and training.

In specified NSW Health entities that have elected to use the ECAT Protocols, nurses are able to initiate care in emergency settings using the ECAT Protocols according to the conditions and processes described in this Policy Directive.

The ECAT Protocols can be used until the medication management or care is taken over by a medical practitioner or nurse practitioner or where care is otherwise taken over by a physiotherapist.

SUMMARY OF POLICY REQUIREMENTS

The Policy Directive outlines the requirements for use of the ECAT Protocols by registered and enrolled nurses working in specified settings/circumstances of emergency care settings.

This Policy Directive describes the governance roles and responsibilities for the use of the ECAT Protocols. This includes the Agency for Clinical Innovation's role in the development, management, evaluation and review of the ECAT Protocols, the role of specified NSW Health entities in ensuring adequate governance and processes are in place for implementation and use of the ECAT Protocols, and the role of nursing leadership teams who must support the implementation and facilitate the education and training required for ongoing use of the ECAT Protocols.

The ECAT Protocols cover a range of paediatric and adult presentations and are designed to be used to initiate emergency care in specified settings, including in Emergency Departments and as part of an organisation's locally approved clinical escalation response (CERS) in designated settings where there is no available medical practitioner or nurse practitioner.

Nurses must always consider their scope of practice, use their clinical reasoning skills and be aware of cognitive bias when using the ECAT Protocols. Enrolled and registered nurses must fulfill the education and training requirements outlined in this Policy Directive and the ECAT Education and RPL Guide before they are able to use the ECAT Protocols.

Registered nurses working within a specified NSW Health entity who fulfill the education requirements as outlined in this Policy Directive are authorised to initiate medications under protocol according to an Authority instrument issued by the Health Secretary under the *Poisons and Therapeutic Goods Act 1966* (NSW) and the *Poisons and Therapeutic Goods*

Regulation 2008 (NSW). This ability to *initiate* medication, as distinct from supply (by way of administration) is limited to registered nurses and does not apply to enrolled nurses.

The ECAT Protocols follow a standardised format that includes history taking, signs and symptoms, red flags, A-G clinical assessment and specified interventions, focused assessments, interventions and diagnostics. Nurses using the ECAT Protocols must work sequentially through the sections of the ECAT Protocols before initiating any interventions or diagnostic requests. Care provided using an ECAT Protocol must adhere to the specific Protocol that is in use and ECAT Protocols cannot be altered.

When nurses initiate care under an ECAT Protocol, they must comply with documentation requirements under the nursing Standards for Practice and NSW Health policies. Documentation must include which ECAT protocol/s have been used, the findings from patient clinical assessment, any requested investigations and any interventions that have been provided.

Where facilities use virtual care to support emergency care, the virtual care service must have access to the ECAT Protocols. Nurses using an ECAT Protocol must refer to the ECAT Protocol name and number when contacting virtual services.

The use of an ECAT Protocol must stop when medication management or care is taken over by a medical practitioner or nurse practitioner or where care is otherwise taken over by a physiotherapist.

Handover of care must include any interventions, medications or investigations that have been ordered, performed or administered, and must include any response to treatment. Once the application of an ECAT Protocol has stopped ongoing nursing care must continue as appropriate.

System, any amendments (regardless of how minor they are) will require the document to be rescinded and reissued with a new reference number.

REVISION HISTORY

Version	Approved By	Amendment Notes
PD2023_039 November-2023	Secretary, NSW Health	New policy directive

NSW GOVERNMENT

NSW Health

The Use of Emergency Care Assessment and Treatment (ECAT) Protocols

CONTENTS

1. BACKGROUND

Emergency Care Assessment and Treatment (ECAT) is a state-wide, co-designed program for use in a *specified NSW Health entity* that standardises nurse-initiated emergency care, reduces unwarranted clinical variation and improves patient experiences and staff satisfaction. The ECAT Protocols are only intended to apply in specified settings/circumstances of a specified NSW Health entity.

The ECAT Protocols have been developed to support registered and enrolled nurses to initiate emergency care according to their relevant scope of practice, in accordance with the ECAT Protocols, and following the completion of prerequisite education and training.

The ECAT Protocols represent best practice clinical guidance and are based on a thorough evaluation of the evidence from existing local guidelines, published research studies, and expert consensus for the management of patients presenting to the emergency department (ED). They support the consistent delivery of timely clinical care for patients across rural, regional and metropolitan settings where emergency care is provided.

The ECAT Protocols cover a broad range of adult and paediatric emergency presentations. If a Local Health District or Specialty Health Network determines the ECAT Protocols are to be used in a NSW Health facility, the full suite of Protocols must be made available for use. Some Protocols will be used more than other Protocols due to the variety of emergency care contexts across NSW Health, variations in population groups, and emergency department presentation trends.

1.1. About this document

This Policy Directive outlines the roles, responsibilities and processes related to the use of the ECAT Protocols in NSW. This includes governance, the knowledge, skills and training required to use the ECAT Protocols, recognition of prior learning, the key components of the ECAT Protocols, and requirements for using the ECAT Protocols.

This Policy Directive also outlines the settings where the ECAT Protocols may be used, and the mandatory requirements for registered nurses and enrolled nurses to use the ECAT Protocols to initiate emergency care until the medication management or care is taken over by a medical practitioner or nurse practitioner or where care is otherwise taken over by a physiotherapist.

1.2. Key definitions

A-G systematic assessment	A structured approach to physical assessment that considers a patient's airway, breathing, circulation, disability, exposure, fluids, glucose.[1]
Clinical Emergency Response System (CERS)	A formalised system for staff, patients, carers and families to obtain timely clinical assistance when a patient deteriorates (physiological and/or mental state). The CERS includes the facility-based and specialty unit based responses (clinical review and rapid response), as well as the formalised referral and escalation steps to seek expert clinical assistance and/or

	request for transfer to other levels of care within the facility (intra-facility) or to another facility (inter-facility).[1]
ISBAR	An acronym for Introduction, Situation, Background, Assessment and Recommendation. A structured communication tool.[1]
Medical Practitioner	A person registered under the Health Practitioner Regulation National Law as a medical practitioner who is authorised under that Law to use that name and who is employed or engaged at a specified NSW Health entity. This does not include medical students.
Nurse Practitioner	A nurse practitioner (NP) is a registered nurse endorsed as an NP by the NMBA who is employed or engaged at a specified NSW Health entity. This endorsement is in accordance with Health Practitioner Regulation National Law.[4]
Physiotherapist	A person registered under the Health Practitioner Regulation National Law as a physiotherapist who is authorised under that Law to use that name and who is employed or engaged at a specified NSW Health entity.
Specified settings/circumstances	• emergency departments (role delineation 1,2,3,4,5 and 6)[16]. • as set out in a specified NSW Health entity's locally approved Clinical Emergency Response System (CERS) response (including any approved CERS response regarding virtual emergency models of care) where there is no available medical practitioner or nurse practitioner – see NSW Health Policy Directive *Recognition & Management of patients who are deteriorating* (PD2020_018).[1] • An area specified in writing during a disaster situation by a Chief Executive of the specified NSW Health entity.
Specified NSW Health entity	• a Local Health District, including a hospital controlled by a Local Health District, within the meaning of the Health Services Act 1997 (NSW) • a hospital controlled by the Crown (including the Minister or the Health Administration Corporation) • the affiliated health organisation St Vincent's Hospital Sydney Limited, and

	• The Sydney Children's Hospital Network.
Triage	Triage is the process of assessment of a patient on arrival to the emergency department to determine the priority for medical care based on the clinical urgency of the patient's presenting condition. Triage enables prioritisation of limited resources to obtain the maximum clinical utility for all patients presenting to the emergency department.[5]

1.3. Legal, legislative and policy framework

This Policy Directive must be read and applied alongside the following professional standards, legislation and NSW Health Policies. Relevant legislation includes (but is not limited to) the *Poisons and Therapeutic Goods Act 1966* and its regulation, the *Drug Misuse and Trafficking Act 1985* and its regulation, and the *Health Practitioner Regulation National Law* (NSW) No 86a of 2009 and its regulation

1.3.1. Nursing and Midwifery Board of Australia (NMBA)

Registered and enrolled nurses working in specified NSW Health entities who use the ECAT Protocols are accountable for their nursing practice and must adhere to the following:

- Registered Nurse Standards for Practice[6]
- Enrolled Nurse Standards for Practice[7]
- Code of Conduct for Nurses[8]
- International Council of Nurses Code of Ethics[9]
- Decision-Making Framework for Nursing and Midwifery[10]

1.3.2. Health practitioners

All health practitioners must be suitably trained and qualified to practise in a competent and ethical manner, and registered to practice in accordance with the Health Practitioner Regulation National Law.[11].

1.3.3. Medication initiation and administration

There is an Authority instrument issued by the Health Secretary (or delegate) under the *Poisons and Therapeutic Goods Act* 1966 (NSW) and the *Poisons and Therapeutic Goods Regulation 2008* (NSW)[2] which enables a registered nurse working within a NSW Health or affiliated health organisation to initiate medications subject to compliance with this Policy Directive and the relevant ECAT Protocol. Registered nurses using the ECAT Protocols are therefore 'administering under protocol' and medication orders do not require a medical practitioner, nurse practitioner, or other authorised practitioner to sign off.
The Authority instrument also authorises enrolled nurses to administer (but not initiate) medication under the supervision of an authorised registered nurse, when acting in accordance with this policy directive and the ECAT Protocols.

To maintain authority to supply (by way of administration) medicines within the ECAT protocols, health services must ensure that nurses have maintained proficiency in current practices relating to the substances referred to in the protocols.

The ECAT Protocols must be used in accordance with requirements as outlined in:

- NSW Health Policy Directive *Medication Handling* (PD2022_032)
- NSW Health Policy Directive *Electronic Medication Management System Governance and Standards* (PD2019_050)

1.3.4. Ionising radiation

Requests for diagnostic imaging are to comply with the following:

- Radiation Control Act 1990 No 13[12]
- Radiation Control Regulation 2013[13]
- Code for Radiation Protection in Medical Exposure (2019)[14]
- Royal Australian & New Zealand College of Radiologists (ANZCR) - Standards of Practice of Clinical Radiology, V11.2[15]

1.3.5. Infection prevention and control

When using an ECAT protocol nurses must adhere to the NSW Health Policy Directive *Infection Prevention and Control Policy* (PD2017_013).

1.3.6. Health care records – documentation and management

When documenting any assessment or care provided using an ECAT Protocol, nurses must adhere to the NSW Health Policy Directive *Health Care Records - Documentation and Management* (PD2012_069).

1.3.7. Emergency Departments

When ECAT Protocols are used in an Emergency Department nurses must adhere to the following:

- NSW Health Policy Directive *Emergency Department Patients Awaiting Care* (PD2018_10)
- NSW Health Policy Directive *Triage of Patients in NSW Emergency Departments* (PD2013_047).

1.3.8. Recognition and Management of Patients who are Deteriorating

The ECAT Protocols and associated prerequisite education modules (as outlined in the NSW Health ECAT Education and RPL Guide) have been designed to align, comply and be used with the NSW Health Policy Directive *Recognition and Management of Patients who are Deteriorating* (PD2020_018).

1.3.9. Incident Management

Any actual or near miss incident which occurs while an ECAT Protocol is in use must be reported according to the NSW Health Policy Directive *Incident Management* (PD2020_47). This includes:

- reporting all actual or near miss incidents in IMs+, ensuring the term ECAT is included if an ECAT Protocol has potentially caused or contributed to the incident.

2. GOVERNANCE

The following governance roles and responsibilities must be in place for the Emergency Care Assessment and Treatment (ECAT) Protocols to be used.

2.1. Agency for Clinical Innovation, NSW Health pillars and NSW Ministry of Health branches

The Agency for Clinical Innovation must provide leadership that supports the development, management, and defined periodical review and improvement of the ECAT Protocols. The protocol review process and timelines are outlined in the Emergency Care Assessment and Treatment Protocol development consultation and review process report.

The Agency for Clinical Innovation will work with other NSW Health pillars, such as the Health and Education Training Institute, the Clinical Excellence Commission and eHealth, and NSW Ministry of Health branches to determine the prerequisite requirements, including education and training requirements, safety processes and use of digital tools, to support the ongoing participation of registered nurses and enrolled nurses to use ECAT Protocols.

The Agency for Clinical Innovation will liase with appropriate Ministry of Health Divisions to ensure appropriate management of issues related to scope of practice determination and industrial relations, state-wide safety issues and monitoring of the impact of the protocols on access and timeliness of emergency care.

The Agency for Clinical Innovation will lead the evaluation of ECAT Protocol use in collaboration with other NSW Health pillars, NSW Ministry of Health branches and Local Health Districts and Specialty Health Networks.

2.2. Local Health Districts and other specified NSW Health entities

Specified NSW Health entities must not alter or adapt the content of the ECAT Protocols.

It is the responsibility of specified NSW Health entities to:

- Delegate clear roles and responsibilities to enable registered nurses and enrolled nurses to use ECAT Protocols.

- Support the implementation and ongoing use of ECAT Protocols where they will be used within local emergency care settings.

- Determine which site/s will be authorised to use the ECAT Protocols, considering local service needs, escalation processes and prerequisite education and training requirements.
- Support the rescinding of existing local standing orders (replaced by the ECAT Protocols) when their site is ready to implement the ECAT Protocols.
- Ensure any registered nurse or enrolled nurse who is required to use the ECAT Protocols has completed the prerequisite education and training; maintained records of completion; and undertakes annual reviews of use of the ECAT Protocols, including medication use.
- Facilitate the ECAT recognition of prior learning (RPL) process for nurses who have existing knowledge, skills and training (see Section 4 *Knowledge, skills and training requirements*)
- Include the monitoring of the use of the ECAT Protocols within existing safety and quality frameworks and NSW Health Policies and Guidelines.

2.3. Nursing leadership teams in emergency care settings

Nursing leadership teams (such as Nurse Managers, Nursing Unit Managers, Clinical Nurse Consultants, Nurse Educators, Nurse Practitioners and Clinical Nurse Educators) must:

- Support the implementation and ongoing use of ECAT Protocols within local emergency settings.
- Include the prerequisite ECAT education and training within local nursing orientation processes.
- Facilitate the necessary education and training that will support nurses working in emergency care settings to use the ECAT Protocols (see Section 4 *Knowledge, skills and training requirements*).
- Include a review of the use of ECAT protocols, including medicines usage, in annual performance reviews for nurses working in emergency settings.
- Provide clinical guidance at the point of care for nurses working in emergency care settings using the ECAT Protocols.

3. USE OF THE ECAT PROTOCOLS

The Emergency Care Assessment and Treatment (ECAT) Protocols have standardised content, however the use of a Protocol may vary according to local contexts and available resources (such as locally approved Clinical Emergency Response System (CERS) processes and the availability of radiology and pathology services).

When used in an emergency department, the ECAT Protocols are to be used after the patient is triaged and prior to the acceptance of care by a medical practitioner, nurse practitioner or physiotherapist. After a medical practitioner, nurse practitioner or physiotherapist accepts care of the patient, application of the ECAT Protocol by the registered nurse or enrolled nurse must stop. Ongoing nursing care must continue as appropriate.

The ECAT Protocols do not replace the need for assessment and treatment by a medical practitioner, nurse practitioner or physiotherapist, nor do they authorise a nurse to discharge a patient prior to consultation.

Where there is no medical practitioner, nurse practitioner or physiotherapist onsite, the nurse must follow local processes to facilitate a consultation. In this situation the nurse can continue using the relevant ECAT Protocol until the until the medication management or care is taken over by a medical practitioner or nurse practitioner or where care is otherwise taken over by a physiotherapist.

The ECAT Protocols are available online at https://aci.health.nsw.gov.au/ecat and in print. A QR code is included on the printed versions to allow nurses to check that they are accessing the current version of a Protocol.

Where the requirements of this policy have been met, the ECAT Protocols can be used in specified NSW Health entities to provide emergency care in the following specified circumstances/settings:

- emergency departments (role delineation 1,2,3,4,5 and 6)[16].
- as set out in a specified NSW Health entity's locally approved Clinical Emergency Response System (CERS) response (including any approved CERS response regarding virtual emergency models of care) where there is no available medical practitioner or nurse practitioner – see NSW Health Policy Directive *Recognition & Management of patients who are deteriorating* (PD2020_018).[1]
- an area specified in writing during a disaster situation by a Chief Executive of the specified NSW Health entity.

3.1. Conditions for registered nurses and enrolled nurses to use ECAT Protocols

Registered nurses working in settings where emergency care is provided must:

- Only initiate ECAT Protocols once they have successfully completed the prerequisite education outlined in Section 4 *Knowledge, Skills and Training Requirements*.
- Follow the ECAT Protocol for assessment, investigations and diagnostics appropriate to the patient's presenting problem.
- Only administer the substance in accordance with the ECAT Protocols and this Policy Directive.
- Remain aware of and consider their level of knowledge, skills, and scope of practice when making clinical decisions and escalate care accordingly.
- Use clinical reasoning and be aware of cognitive bias when using the ECAT Protocols.
- Recognise and respond to Yellow and Red Zone criteria and Red Flags according to the NSW Health Policy Directive *Recognition and management of patients who are deteriorating* (PD2020_018) and locally approved CERS processes.
- Maintain proficiency in current practices relating to the substances referred to in the ECAT Protocols.

Enrolled nurses working in settings where emergency care is provided must:

- Only use the ECAT Protocols under the supervision of a registered nurse. This includes consulting with a registered nurse to identify which protocol will be used before initiating care with an ECAT Protocol and documenting that decision.
- Only use ECAT Protocols once they have successfully completed the prerequisite education outlined in Section 4 *Knowledge, Skills and Training Requirements*.
- Only administer the substance in accordance with the ECAT Protocols and this Policy Directive, including to only use the unshaded portions of the ECAT Protocols, using the content as a guide to inform assessment and management.
- Not initiate any medications under an ECAT Protocol.
- Follow the ECAT Protocol for assessment, investigations and diagnostics appropriate to the patient's presenting problem.
- Remain aware of and consider their level of knowledge, skills, and scope of practice when making clinical decisions and escalate care accordingly.
- Interpret patient assessment data and notify the registered nurse if a red flag or change in the patient's condition is recognised.
- Recognise and respond to Yellow and Red Zone criteria and Red Flags according to the NSW Health Policy Directive *Recognition and management of patients who are deteriorating* (PD2020_018) and locally approved CERS processes.
- Maintain proficiency in current practices relating to the substances referred to in the ECAT Protocols.

3.1.1. Scope of practice

Registered and enrolled nurses can only use the ECAT Protocols within their scope of practice. The scope of practice of an individual is that which they are educated, authorised and competent to perform. An individual's scope of practice is also determined by the employer's requirement (position description) to perform their role. Registered and enrolled nurses must decide whether a task is within their scope of practice, whether they are the most appropriate person to perform that task, and whether they have been supported by their organisation to perform that task. This is consistent with the NMBA decision making framework.[10]

4. KNOWLEDGE, SKILLS AND TRAINING REQUIREMENTS

The Emergency Care Assessment and Treatment (ECAT) Protocols are designed to be used according to a registered nurse and an enrolled nurse's individual level of knowledge, skills and training and subject to the requirements of this Policy Directive.

In addition to the knowledge, skills and training requirements outlined in Section 4, registered and enrolled nurses must have completed courses that are targeted as part of the State-wide Mandatory Training Policy (red flagged in My Health Learning) and courses that are targeted

by Local Health District Chief Executives (blue flagged in My Health Learning) prior to using the ECAT Protocols. This includes the Between the Flags Learning Pathways that are relevant to a nurse's patient cohort (adult and/or paediatric). This is outlined in the NSW Health ECAT Education and RPL Guide.

Registered and enrolled nurses must maintain proficiency in current practices relating to the substances referred to in the ECAT Protocols.

4.1. Recognition of prior learning

Recognition of prior learning (RPL) is the formal acknowledgment and assessment of evidence of a nurse's skills, knowledge and capabilities obtained as a result of prior learning.[17]

The NSW Health ECAT Education and RPL Guide supports the implementation of the ECAT Protocols across NSW and has been developed to recognise existing emergency nursing education programs and clinical practice. When granting RPL the nursing leadership team must use the NSW Health ECAT Education and RPL Guide. The NSW Health ECAT Education and RPL Guide is informed by existing emergency nursing education programs and the following Codes, Standards, Guidelines and Frameworks:

Nurses and Midwives Board of Australian Codes, Standards and Guidelines

- Registered Nurses Standards for Practice[6]
- Enrolled Nurse Standards for Practice[7]
- Code of Conduct for Nurses[8]
- International Council of Nurses Code of Ethics[9]
- Decision-making framework for nursing and midwifery[10]

College of Emergency Nursing Australia

- Practice Standards for the Specialist Emergency Nurse[18]

NSW Health Emergency Nursing Capability Framework[19]

Assessment of RPL must be undertaken locally by members of the nursing leadership teams in settings where emergency care is provided. It is the responsibility of the nurse to provide evidence of prior education and training for this assessment to be completed. The RPL must be uploaded into My Health Learning by the member/s of the nursing leadership team assigning the RPL.

4.2. Prerequisite education and training

Registered nurses and enrolled nurses must complete the following prerequisite core education and training modules (available in My Health Learning) prior to using the ECAT Protocols:

- Nursing in Emergency Care Settings

and

- ECAT – Introduction to protocols.

4.2.1. Specific protocol prerequisite education and training

The Acute Behavioural Disturbance ECAT Protocol is only to be used by nurses who have completed the NSW Health *Emergency Department Violence Prevention Management (EDVPM) Learning Pathway*.

4.3. Protocol shading

The ECAT Protocols include unshaded and shaded sections to delineate where different levels of knowledge, skill and training are required for initiating treatments (including medications) or investigations. To assist nurses with colour vision deficiency, shaded sections also include a shape symbol (diamond or triangle).

4.3.1 Unshaded portions

Enrolled nurses may only use the unshaded portions of the ECAT Protocols and only once they have successfully completed the prerequisite education and training (see Section 4.2 *Prerequisite education and training*) and only under the supervision of a registered nurse. The unshaded portions are only to be used as a guide to inform patient assessment and management. Enrolled nurses are not authorised to initiate any medications under an ECAT Protocol.

Registered nurses can use all of the unshaded portions of the ECAT Protocols once they have successfully completed the prerequisite education and training (see Section 4.2 *Prerequisite education and training*).

Registered and enrolled nurses may only perform peripheral cannulation and venepuncture and request pathology as outlined in the relevant Protocol if they have completed the NSW Health course Peripheral Intravenous Access for Adults and Paediatrics or have demonstrated recognition of prior learning according to the NSW Health ECAT Education and RPL Guide (see Section 4.1 *Recognition of prior learning*).

4.3.2 Diamond / pink shaded portions

Only registered nurses can use the diamond/pink shaded portions of the ECAT Protocols, and only once they have successfully completed the 'Transition to Specialty Emergency Practice' Program or have demonstrated prior learning according to the NSW Health ECAT Education and RPL Guide (see Section 4.1 *Recognition of prior learning*).

4.3.3 Triangle / blue shaded portions

Triangle/blue shaded portions of the protocols cover a variety of interventions and investigations.

Only registered nurses can use the triangle/blue shaded portions of the ECAT Protocols, and only the specific intervention/investigation where they have successfully completed the relevant education and training component (in Table 1 *Triangle/blue shaded portion and associated training requirements*).

Table 1. Triangle/blue shaded portion and associated training requirements

Intervention / Investigation	Designation	Education and Training Component
Intraosseous cannula insertion	Registered nurse only	Education and training according to NSW Health ECAT Education and RPL Guide
Splinting and slings	Registered nurse only	Education and training according to NSW Health ECAT Education and RPL Guide
Nurse-initiated x-ray	Registered nurse only	Education and training according to NSW Health ECAT Education and RPL Guide
Wound closure, including suturing	Registered nurse only	Education and training according to NSW Health ECAT Education and RPL Guide
Nitrous Oxide administration	Registered nurse only	Education and training according to NSW Health ECAT Education and RPL Guide
Adult Advanced Life Support level 1 interventions and/or medications	Registered nurse only	Education and training according to NSW Health ECAT Education and RPL Guide
Adult Advanced Life Support level 2 medications	Registered nurse only	Education and training according to NSW Health ECAT Education and RPL Guide
Paediatric Advanced Life Support interventions and/or medications	Registered nurse only	Education and training according to NSW Health ECAT Education and RPL Guide
Nurse administered thrombolysis	Registered nurse only	Education and training according to NSW Health Policy Directive *Nurse Administered Thrombolysis for ST Elevation Myocardial Infarction (STEMI)* (PD2022_055)

5. PROTOCOL FORMAT

Emergency Care Assessment and Treatment (ECAT) Protocols have a standardised format, which is outlined in Table 2 *Protocol Format*. The main components of each protocol include history taking, signs and symptoms, red flags, A-G clinical assessment and specified interventions, focused assessments, precautions and notes, interventions and diagnostics, medications, further references and resources, and document intervention.

Table 2. Protocol Format

Protocol Section	Description
History prompts and signs and symptoms	History taking involves gathering subjective and objective data, including but not limited to, the presenting complaint, family, surgical, medical, medication and psychosocial history and infection risk. This section contains history prompts and signs and symptoms that are relevant to the presenting condition to guide the nurse when taking the patient's history.

Protocol Section	Description
	The nurse must refer to this section to confirm the most appropriate ECAT Protocol has been identified to suit the patient's presenting problem.
Red flags	This section consists of historical and clinical indicators of actual or potential clinical severity and risk of deterioration. Red flags may be identified at any time while using an ECAT Protocol. Nurses must respond by: • carefully considering whether an alternative ECAT Protocol would be more appropriate according to the patient's clinical condition, and/or • escalating as per clinical reasoning and locally approved Clinical Emergency Response System (CERS) process, while continuing to provide treatment.
Clinical assessment and specified interventions (A-G)	This section consists of a systematic assessment and relevant interventions. If a patient has any Yellow or Red Zone observations or additional criteria (as per the relevant NSW Standard Emergency Observation Chart), the nurse is to refer and escalate as per the locally approved CERS processes and continue treatment. ECAT Protocols advise the nurse to repeat assessments and document observations, to monitor responses to interventions, and to identify developing trends and/or clinical deterioration.
Focused assessment	This section provides a consistent approach to performing a detailed assessment of a specific body system(s). The focused assessment relates to the current presenting problem or concern and must be used to inform requests for investigations.
Precautions and notes	This section alerts the nurse to key considerations when assessing, planning and delivering patient care.
Interventions and diagnostics	Nurses must work within their scope of practice when initiating interventions or requesting diagnostics. Shaded components of the protocols reflect the need for additional education and training (or recognition of prior learning (RPL)) prior to use as outlined in Section 4 *Knowledge, skills and training requirements*. Interventions or diagnostic requests must be informed by the patient history and/or clinical assessment.
Medications	ECAT Protocol medications include the drug dose, route and frequency. Administration should be guided by the patient assessment. Medications that are shaded are only to be ordered by nurses who have completed the prerequisite education or have demonstrated the relevant RPL.
Further references and resources	This section lists the references and resources used to develop each ECAT Protocol.
Document information	This section provides information on how the ECAT Protocol was developed and the currency of the Protocol.

6. INITIATION AND DOCUMENTATION OF CARE USING ECAT PROTOCOLS

When care is initiated using an Emergency Care Assessment and Treatment (ECAT) Protocol, the assessment, investigations and treatment must adhere to that specific Protocol.

A nurse considering the use of an ECAT Protocol must:

- Consider, for patients in Emergency Departments, the triage assessment and category as allocated according to NSW Health Policy Directive *Triage of Patients in NSW Emergency Departments* (PD2013_047) to inform their decision when identifying the most appropriate ECAT Protocol for use.
- Confirm the most appropriate paediatric or adult Protocol by considering the patient's age, history and by checking the signs and symptoms (including red flags) listed on the Protocol.

Where there is more than one appropriate Protocol, the Protocol which addresses the higher acuity problem should be used. This decision should be informed by considering:

- the priorities of 'airway, breathing and circulation'; and
- which protocol most closely reflects the triage presenting problem and category.

In the event there is not an appropriate ECAT Protocol, nurses must continue to provide appropriate, timely patient assessment and care. The use of an ECAT Protocol must stop when care of the patient has been commenced by a medical practitioner, nurse practitioner or physiotherapist.

6.1. Recording Nurse Seen Date and Time

The ECAT Protocols fulfill the requirements for 'nurse seen date time' as outlined in the NSW Health Policy Directive *Emergency Department Data Dictionary* (PD2009_071). Where available, nurses must use the relevant adult or paediatric 'ED Approved Protocol' electronic form (or local equivalent which allows for use of a specific ECAT Protocol to be recorded), to indicate which ECAT Protocol has been initiated. This will auto populate the nurse seen date and time in the electronic medical record.

When using an ECAT Protocol the requirements for nurse seen date and time will be considered as fulfilled when all of the following requirements have been met:

1. Identification and documentation of an appropriate ECAT Protocol
2. Initiation of care by the nurse, commencing with a patient assessment (including patient history) according to the patient's presenting problem
3. The intention to continue nurse-initiated assessment and treatment under the ECAT Protocol until care of the patient is taken over by a medical practitioner, nurse practitioner or physiotherapist.

6.2. General Documentation

When care is initiated under an ECAT Protocol, the nurse must document the ECAT Protocol name and number (including related information regarding patient assessment, interventions and diagnostics). Documentation must comply with the following:

- The Registered Nurse Standards for Practice (2016)[6]
- The Enrolled Nurse Standards for Practice[7]
- NSW Health Policy Directive *Health Care Records – Documentation and Management* (PD2012_069)

6.3. Switching protocols

Registered nurses may choose to select a different ECAT Protocol to what was initially commenced if the findings of the patient history and assessment reflect a more suitable alternative protocol. This is referred to as 'switching Protocols'. It may also be appropriate to switch Protocols if a patient deteriorates, while escalating as per the local Clinical Emergency Response System (CERS) process. The change in Protocol must be documented as a progress note with a rationale for the change.

If an enrolled nurse is following a protocol and the patient's condition changes, they must notify the supervising registered nurse who can determine if the enrolled nurse can switch Protocols.

When a Protocol switch is made an adhoc 'ED Approved Protocol _switch' electronic form (or local equivalent which allows the switch to an alternative ECAT Protocol to be recorded) must be completed to that reflect the change in Protocol.

6.4. Requesting and documenting pathology requests

Nurses using the ECAT Protocols may only request pathology as stated and indicated within the applicable Protocol. If additional pathology requests are required, escalation to a medical practitioner or nurse practitioner is needed.

Nurses must undertake a patient assessment and consider presenting signs and symptoms prior to arranging pathology requests. When working in a team environment, a registered nurse can delegate venepuncture and cannulation procedures to appropriately trained staff (e.g., to technical assistants or assistants in medicine), however the registered nurse retains responsibility for the patient's care and for requesting investigations.

The results from all pathology requested under ECAT Protocols must be reviewed by the attending medical practitioner or nurse practitioner when they take over care of the patient.

Across NSW emergency facilities, processes are in place for escalation of urgent pathology results. Nurses must adhere to these processes and escalate to a medical practitioner or nurse practitioner if they are notified of or become aware of such pathology results.

Where possible, pathology requests are to be completed electronically. The nurse must document that pathology sample has been collected and sent according to the ECAT Protocol.

6.4.1. Point of care testing (PoCT)

Based on a patient's condition and available formal laboratory facilities, a nurse who is trained to use point of care testing (PoCT) may elect to use PoCT and/or collect and send formal tests. When PoCT testing is used, the tests performed must be as close as possible to the formal tests outlined in the pathology section of the ECAT Protocols.

If a pathology test was undertaken using a PoCT device, results outside of normal ranges must be escalated under the same process as formal results.

6.5. Requesting and documenting radiological investigations

Only registered nurses who have successfully completed the appropriate education outlined in Section 4 **Error! Hyperlink reference not valid.** are able to request medical imaging.

Radiological imaging may only be requested as stated within the applicable ECAT Protocol. If the nurse or radiographer believes additional radiological imaging is required, escalation to a medical practitioner, nurse practitioner or physiotherapist is needed.

Nurses must undertake a patient assessment and consider a patient's presenting complaint, history, pregnancy status and signs and symptoms prior to requesting medical imaging.

Radiology requests are to be placed electronically where available and must follow local processes. At the beginning of the clinical history the requesting nurse must document 'requested under ECAT Protocol (Protocol name and number)', for example 'requested under ECAT Protocol (Chest Pain A3.2). In the event of a written request, the form is to be completed legibly including the name of the nurse requesting the investigation.

At a minimum the request must document a succinct and specific description of the:

- patient's details and demographics, including pregnancy status for females
- history / mechanism of injury
- assessment findings
- site of pain / region of interest
- clinical question / provisional diagnosis
- signature, or electronic signature as well as contact details of requesting nurse.

All imaging requested under ECAT Protocols must be reviewed by the medical practitioner, nurse practitioner or physiotherapist when they take over care of the patient.

Across NSW emergency facilities, there are processes in place for the escalation of urgent radiology results. Nurses must adhere to these processes and escalate to the medical practitioner, nurse practitioner or physiotherapist if they are notified of or become aware of such a radiology result.

6.5.1. Radiological Investigations - Special considerations

In sites where there is no onsite medical imaging or radiographer available the nurse must, consult with either a medical practitioner, nurse practitioner or physiotherapist:

- before requesting an on-call radiographer to be called back according to local call back procedures.
- to discuss the need for a possible transfer to another site where medical imaging is available.
- before contacting a remote operator to undertake medical imaging.

6.6. Medication ordering, administration and documentation

The ECAT Protocols must be used in accordance with the NSW Health Policy Directive *Medication Handling* (PD2022_032).

Registered nurses who have completed the prerequisite education and training outlined in Section 4 *Knowledge, skills and training requirements* have been authorised by the Health Secretary (or delegate) to initiate medicines under ECAT Protocol via an Authority instrument, subject to complying with the conditions of the authority (including a requirement to only administer medication in accordance with this policy and the ECAT Protocols).

To order medication, the Registered Nurse who is authorised to initiate medication must:

- hold primary responsibility for direct clinical care.
- only initiate medicines when they have followed the components of the ECAT Protocol as outlined in Section 5 *Protocol format.*
- only initiate medicines according to their scope of practice and to the level of knowledge, skill and training as outlined in Section 4.3 *Protocol shading*.

Other registered nurses or enrolled nurses may administer medicine once ordered by the registered nurse who is authorised under the Authority instrument; and can only administer the substances in accordance with this policy and the ECAT Protocols (including in relation to undertaking the required training prior to administration). In this situation the authorised registered nurse remains responsible for the patient's care. This supports a team approach to patient care.

Nurses who have not completed prerequisite education and training must not request registered nurses authorised under the authority instrument to order medicines for their patients. In circumstances where a patient requires medicines and the nurse is not authorised to order these, then handover of care must occur to a registered nurse authorised to initiate medication under the authority instrument, who must then complete a full history and assessment prior to initiating any medication.

Medications must be strictly administered according to the indication and medication, dose route and frequency as outlined on the ECAT Protocol.

Prior to a registered nurse initiating or administering a medication, the nurse must:

- ensure the patient does not have a known allergy and/or adverse drug reaction to the medication.
- be aware of any medication/s which the patient has self-administered or been given by paramedics in the prehospital period.

- ascertain that no other formulations of the same medication are concurrently being prescribed or administered.
- remain aware that medication may interact with the patient's prescribed regular medications.
- check any precautions and indications using medication reference texts. Relevant sources are hyperlinked in the ECAT Protocol medication tables in the online versions. Where renal or hepatic dose adjustments or contraindications need to be considered, these are indicated by the superscripts 'R' and 'H' in the medication table.

The ECAT Protocols are not designed to be altered, therefore any need to deviate from the ECAT Protocol drug, dose, route, or frequency (which may arise due to patient factors or medication contraindications) requires escalation to a medical practitioner or nurse practitioner.

6.6.1. Electronic Medication Management (eMM)

When an electronic medication chart is available, the authorising nurse must order the medication through the relevant local electronic medication management procedure and according to NSW Health Policy Directive *Electronic Medication Management System Governance and Standards* (PD2019_050).

When ordering a medication under an ECAT Protocol, the date, medication name, dose, route of administration and time of order must be included in the order. The authorising nurse must sign the order.

The administering nurse must record the administration and the effect of the medication in the patient's medical record.

6.6.2. Paper-based National Standard Medication Chart

Where an electronic medication management system is not in use, the National Standard Medication Chart and associated guidelines published by the Australian Commission for Safety and Quality in Healthcare must be adopted.

When a National Standard Medication Chart is required, the authorising nurse must record the medication order, including the the date, medication name, dose, route of administration and time of order in ink on the 'once-only and nurse-initiated medicines and pre-medications' section of the chart as 'ECAT', then print and sign their name in the prescriber/ nurse-initiated section.

The administering nurse must sign the medication chart and document the effect of the medication in the patient's medical record.

6.6.3. Accountable Drug Register

When a Schedule 4 Appendix D and / or Schedule 8 medication administration is required under an ECAT Protocol, the Schedule 4 Appendix D and/ or Schedule 8 drug register must be completed according to NSW Health Policy Directive *Medication Handling* (PD2022_032). The name of the registered nurse authorised under the authority instrument to initiate the

medication should be written in the 'prescriber' column and 'ECAT' next to the name for example, 'SMITH, ECAT'.

When a Schedule 4 Appendix D and / or Schedule 8 medication administration is required and an Automated Dispensing Cabinet is in use, the administering nurse and witness must adhere to local procedures for dispensing and documenting the medicines. There are statutory reporting obligations (punishable by a fine of $2,200 for non-compliance) to immediately notify the Health Secretary of any loss or theft of Schedule 4D and Schedule 8 substance.

7. HANDOVER OF CARE

Handover in emergency settings must adhere to NSW Health Policy Directive *Clinical Handover* (PD2019_020).

When handing over care of the patient to the medical practitioner, nurse practitioner or physiotherapist, the nurse must, where possible, use the Introduction, Situation, Background, Assessment and Recommendation (ISBAR) handover tool and document in the progress notes of the patient record according to local procedures. This should include any interventions, medications given, or investigations ordered under the Emergency Care Assessment and Treatment (ECAT) Protocol and any response to treatment.

After care is taken over by the medical practitioner, nurse practitioner or physiotherapist, application of the ECAT Protocol must stop. Ongoing nursing care must continue as appropriate.

8. VIRTUAL CARE

Where a service provides virtual care support for an emergency setting, the Emergency Care Assessment and Treatment (ECAT) Protocols must be available for the reference of the referrer and the clinicians providing virtual support.

Registered nurses who are required to use virtual care as part of their locally approved emergency department model of care must refer to the ECAT Protocol name and number when referring to the use of an ECAT Protocol.

Registered nurses who are required to use virtual care as part of their local Clinical Emergency Response System (CERS) process must be familiar with the appropriate escalation process and use of relevant virtual care equipment before initiating care under an ECAT Protocol. Use of the ECAT Protocols must not delay a referral to virtual services.

When a patient is assessed through virtual care by a medical practitioner, nurse practitioner or physiotherapist, the ECAT Protocol must stop. The medical practitioner, nurse practitioner or physiotherapist then has responsibility for directing the patient's care.

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