# Medical Officer Orientation- Prince of Wales Emergency Department

***Registrar Term 4***
***JMO Term 5***
***October 2020***
***David Murphy/Therese Becker/ Sarah Gollance***

***<u>Welcome</u>***

Prince of Wales Emergency Department is a busy, tertiary Emergency Department. We saw approximately 63,000 patients in 2019.

In 2020, the COVID pandemic has been the key challenge we have faced. Your ED term will an important opportunity to support the community through this and to witness significant change in our health system. The ED has made several changes to its workflow- especially relating to isolation practices and staff safety, and further change is expected as the pandemic progresses.

As a whole, our patient mix is of high acuity and complexity, with an admission rate of approximately 40%. We see adults (from 16$^{th}$ birthday) from a highly varied local population from Waverley to Botany Bay, as well as those seeking or referred to us from around the state. We have some special roles: we are the ED serving the Correctional Complex at Long Bay, the ED for one of 2 spinal units in the state, and we are the receiving hospital for Lord Howe and Norfolk Islands. Our patent mix is also influenced by our proximity to beaches, the University of NSW, and the airport. POWH is classified as a Local Hospital within the NSW Trauma Services Plan, and so our ED does not routinely receive major trauma, but we do receive moderate volumes of minor trauma and secondary referrals from throughout NSW for spinal/ neurosurgical care. We have an active Stroke

Service, and a 24/7 Interventional Neuroradiology service. We also have large psychiatric, cardiology and cardiothoracic surgery, renal (including transplant), clinical toxicology, haematology and cancer care services, all of which serve patients from a wide catchment.

Our function is to provide an acute medical service to the community. The ED is an important access-point to the hospital, and acts as a bridge between primary care, other community care and inpatient services. Our particular role is in stabilising and managing the sickest and least differentiated patients and guiding them safely to appropriate inpatient care. Equally important is the role we play in treating acute illness and injury in those who do not currently need inpatient care, but for whom timely and effective treatment can prevent deterioration or disability, and allow return to work and safe return home. Many of our patients come to us in a vulnerable state, not only in relation to their current illness but also in relation to health literacy and a wide spectrum of social and health disadvantage, which we should always seek to identify and address.

As a tertiary teaching hospital, training is also central to our activities. We support and supervise a large number of medical, nursing and allied health students, run an active nursing and prevocational medical program, support a range of senior nursing portfolios including Nurse Practitioner, and have a very active Emergency Medicine (EM) training program.

As a prevocational doctor, you will be attending teaching sessions throughout your term, and will be under the care and guidance of a term supervisor.

For those considering EM training, you should approach the Directors of EM Training (DEMT) for advice. Significant support is offered to trainees by the whole ED team. The training program at POWH includes a wide range of teaching activities and secondments, both for our own trainees and in collaboration with other sites across NSW HETI Network 3, and has a significant record of success in producing Specialist Emergency Physicians. We also support the ACEM Certificate and Diploma programs.

***Demographics***

Our catchment population, roughly the Randwick and Waverley Local Government areas, is over 225,000 people and growing, with wide socio-economic diversity. Over 20% of our patients are aged 75 or over, and this proportion is projected to grow significantly in coming years.
Roughly one in five of us will need to visit an ED in any 12-month period, so a well-functioning ED is important for all of us.

***Junior Medical Officer (JMO) Term objectives and training goals***

During the term, you will be providing medical services to patients attending the ED to the highest standard possible, in support of and under supervision of

senior medical ED staff. The primary expectation we have of you is that you commit fully to an ethical and caring approach to all our patients.
It is the responsibility of consultant staff, and where delegated registrar and senior nursing staff, to ensure that JMOs have appropriate support and supervision both for training and for patient safety.
You will be working in a large multi-disciplinary team, including nursing, allied, clerical and ancillary staff, and your support and respect for the different members and roles within this team will be expected at all times.
You will be representing the ED to other groups, both within and outside the hospital, and will be expected to maintain the highest standards possible in doing so.
You will be expected to participate actively in training, both by attendance at the formal ED education program and by seeking training opportunities based on patients seen in the ED.

**By the completion of this term the JMO may expect to acquire the following knowledge**:

- How to assess, investigate and manage a broad range of undifferentiated emergency presentations, including but not limited to: chest pain; shortness of breath; altered level of consciousness; abdominal pain; trauma; headache, weakness, seizures; poisoning; fever
- Knowledge regarding the indications, performance and risks associated with various procedural skills necessary in the Emergency Department
- Knowledge regarding an holistic approach to patient care with emphasis not only on physical well-being but also mental and social well-being
- Knowledge regarding clinical research being carried out in the emergency department
- Knowledge regarding effective and efficient conduct of emergency care, including clinical responsibility, time management, communication and consultation with the emergency team, gathering and documentation of clinical information, investigation and referral practices, and overall risk management in the ED environment.

**By the completion of this term the JMO may expect to gain competency in the following skills:**

- Appropriate and sensible test investigation and interpretation of the results of those investigations in an emergency context
- Development of management & disposition plans
- Practical skills which may be obtained or observed include: iv cannulation; obtaining blood gases (venous unless by ED consultant approval); suturing; plaster splinting; lumbar puncture; insertion of intercostal tubes; pleural/ peritoneal aspiration; local anaesthesia; advanced life support
- ‘Presenting’ patients to senior colleagues in a coherent fashion

- How to recognise a 'sick patient'
- How to approach a patient with abnormal vital signs
- How to monitor a patient appropriately
- How to know when to ask for help
- How to 'multi-task' under sometimes difficult conditions

***Department Structure***

Administratively the ED forms part of the ***Program for Emergency, Specialist and Continuing Medicine.***

***Acting Director: David Murphy***

***Staff Specialists*** *(and other roles)**:***

Therese Becker (Toxicologist, Co-Director of Emergency Medicine Training)
Betty Chan (Toxicologist)
Angela Chiew (Toxicologist)
Matt Davis (Quality/ incident review)
Michael Golding (Nurse Practitioner support)
Sarah Gollance (PGY1 term supervisor)
Susan Hertzberg (Incident review/ medicolegal)
Andrew Hugman
Daniel Khamoudes (Simulation clinical co-lead)
Jeremy Lawrence (Incident review)
Marian Lee (EDSSU clinical lead)
Claire Leonard (PGY2, Complex Management Plans, Mental health liaison)
Ellen Meyns (Wellbeing)
John Mackenzie (Equipment)
Alvaro Manovel (Ultrasound clinical supervision)
Sally McCarthy (President, International Federation for Emergency Medicine)
David Murphy (Acting Director)
Prianca Prabhakar (Registrar rostering)
Zoe Rodgers (Simulation clinical lead)
Irene Rotenko (Ultrasound Special Skills Lead)
Kate Sellors (Co-Director of Emergency Medicine Training)
Joanna Short (SRMO supervision, gynaecology liaison, medical student coordinator)
Bruce Way (POWH Co-Director Prevocational Education and Training, Ultrasound Clinical Supervision)

Several sessional Visiting Medical Officers/ Locum Staff Specialists also complement our Specialist staff.

***Nursing***
***Acting Nurse Manager: Dominica Lemmich***

Nurse Unit Manager: Dominica Lemmich
Clinical Nurse Unit Managers:
Patricia Maurer
Kathryn Power
Amy Fenton
Chris Ford
Nurse Navigators:
Allan Grimshaw
Kelly Green
Ann-Marie Furner
Nurse Practitioners:
Carmel Hagness
Deborah Tracy
Hayley McGregor
Clinical Nurse Consultant: Wayne Varndell
Clinical Nurse Educator:
Alison Jeffers
Eloise Berry
Kiri Hargreaves
Kylie Howes
ASET Clinical Nurse Consultant: Ann Kelly

The ED has a very large and highly skilled team of nurses in a variety of roles, including nurse specialist and advanced practice roles.
On the floor, in addition to nurses assigned to each treatment area, you will come into contact with the following roles:

- Coordinator: responsible, in liaison with duty consultant, for immediate bed management and placement of new patients;
- Navigator: assists coordinator in placing admitted patients, needs to know about all new admissions or any requests to move patients.
- Triage nurse: will complete triage, place patients in an appropriate area and alert staff of any urgent or important issues.
- Waiting Room Liaison/ Clinical Initiatives Nurses: will monitor waiting patients, observe for any safety issues or deterioration, and undertake under protocol guidance procedures (e.g. x-ray, analgesia) that would be expected to improve or expedite care.
- Nurse Practitioners: Nurse Practitioners see patients independently with support as needed from senior medical staff. They have a range of skills including wound closure and splinting, and will be happy to help you for specific procedures.

***Physiotherapy Practitioners***

The ED is served by a physiotherapy team, led by Jimmy Roumanus, 7 days a week (Mon-Fri 0800 to 1630, Sat-Sun 1000 to 1800), based in Fast-track. Physiotherapists will pick up patients independently within scope of practice, are available for advice or support for other patients (e.g plastering, musculoskeletal advice), and will seek medical support (or transfer of care) when required.

***Senior Clerical/ Administrative Staff***

Medical Workforce Coordinators: Adrianne Love/ Judith Lissing
Clerical Manager: Danielle Shephard
Assistant to the Acting Director: Anne MacLauchlan
IT/ Data Manager: Chris Yap
Education Support Officer (medical): Yuen (Annie) Au
Clinical Support Officer (nursing): Sarah Dannaoui
Other important staff members include our Communications clerks, EMR staff, front desk Clerical Staff, Health and Security Assistant(s), ED porters, ED radiology porters, and Patient Services Assistants.


***Department function***

The ED is separated into the following work areas:

- Isolation: Patients with respiratory symptoms or who otherwise need isolation. This includes patients whose isolation requirements cannot be determined, such as the initial phase of care in out-of-hospital cardiac arrest.
- Acute: Patients who do not have isolation requirements identified at triage, but who are identified as needing monitoring or 'horizontal' bed-based care.
- Cubicles/ Fast-track. Comprising 7 cubicles with beds, eye, plaster and procedure rooms, and an open area with 9 recliner-chair treatment spaces, this area is geared for 'vertical' patients who are at low risk for COVID and do not require a bed for ongoing care.

- Emergency Department Short Stay Unit (EDSSU): 15 beds for admissions up to 24 hours including monitored bed capacity under ED management. An EDSSU Business Rule is found on the ED SharePoint.

Computers on wheels (COWs) and fixed PCs are available throughout the ED to allow efficient electronic documentation and access to information. All documentation is done electronically, and COWs can assist this very much. Please leave them on charge when not in use.

Other important areas include:

- Reception, with clerical area and triage. If you require information to be faxed from another doctor or hospital, please use the fax machine in the clerical office. The number is 9382-3966. An alternate fax at the main bridge is 93823911. You will need to check periodically for the fax's arrival, or alternatively ask the clerical staff to keep an eye out for it**.**
- Ambulance Bay
- ED Offices and Conference Room
- ED tea room
- Storage areas

Lockers are available- please see Adrianne Love to arrange a key.


***<u>Relationship with Other services</u>***

Patients may present to ED via private transport, by ambulance, or occasionally from other services in the hospital. Referrals from admitting specialty services in hours should be via the Patient Flow Unit rather than to ED, unless it is anticipated that a patient may be unstable or need urgent ED care. Inter-hospital transfers do not come to ED unless unforeseen deterioration occurs enroute or,

in rare circumstances, when transfer for specific specialty care is urgent and an appropriate bed, though not yet available, is expected. A patient arriving after-hours from another hospital may pass through the ED for stability assessment (and treatment if required), clerical registration and ward bed confirmation. If stable, we would then contact the after-hours ward staff to complete an admission.

Our relationships with community general practice, aged care/ social support services and community specialist services are very important. The care of our patients should support their relationships with them, and particular attention should be given to communication with them by letter, phone calls, and by the instructions we give on discharge. Referral letters, ambulance sheets and pre-arrival notes should be read and interpreted carefully, and may be valuable sources of information.

Our relationships with inpatient services are also very important, with significant and complex mutual expectations. **Our documentation and communication should be professional and clear, not only relating our patient assessments, but also to consultations and discussions with non-ED teams (NB include names and times).** If any difficulty arises in liaison with non-ED teams, please discuss with an ED registrar or consultant as soon as possible. Some specific services, particularly spinal and renal (in particular relating to transplant or dialysis patients), would like to be contacted whenever a patient under their long-term care is seen for any reason. If in doubt consult senior staff.

***Particular Relationships with Other Services***

POWH ED has some particular relationships, which can be of use to medical staff in the ED. An admissions guide is available on the ED SharePoint and is posted in the clinical areas. Here is a non-exhaustive list:

- Clinical Toxicology; POWH provides a 24 hour regional referral service on **0423366022** led by **Dr Betty Chan**. The Clinical Toxicology Unit also conducts extensive research, both in relation to toxicology and Emergency Medicine. Please contact the on-call toxicologist for any poisoning or overdose. Toxicology assessment forms are preformatted for your EMR notes to help structure the information required. Please discuss with senior ED staff before referral.
- Mental Health: a Mental Health CNC **(page 45260)** is on-site 7 days a week. A staff specialist- led team is available on weekday mornings. The Mental Health registrar is on page at other times.
- ASET: The ED has a well-developed Aged Care Services in Emergency (ASET) team, led by **Ann Kelly and Dasha Riley**, with nursing, social work and physiotherapy, and very good connections with both inpatient and outpatient services. This team is very important in assisting us with safe discharge, identifying and assisting patients who need increased care in

the community, and assists in liaison both with the inpatient geriatric team and with residential aged care services. They can also refer to the Geriatric Outreach Service for support in the home and in Residential Aged Care Facilities (RACF).

- Pharmacy: led by **Dana Strumpman** and Patricia Conaghan provide a 7 day in-hours service to advise and review medication histories, prioritising complex patients, and to facilitate supplies.
- Social work: led by **Annmarie Townsend,** are available in hours for any patient, and after-hours for specified emergencies. Areas of expertise include finding accommodation (homeless or patient relatives if needed), helping arrange transport (including taxi transport is no safe alternative exists), attending families of critically ill or dying patients (see also bereavement packages on the bridge), for miscarriage (see below), **and for advice in all instances of suspected child abuse or neglect, domestic violence or sexual assault**. Information leaflets relating to bereavement and crisis supports can be found in the EDSSU shelves. Non-urgent out-of-hours referrals can be left in the social work book. Please note that our sexual assault service is at Royal Prince Alfred Hospital (95156111) for patients who request formal referral or forensic testing.
- Aboriginal Liaison Officer: Auntie **Linda Boney** is available in working hours for any patient you feel may benefit from her. Page via switch.
- Chaplaincy: a wide range of religious denominations can be and contacted at any time, particularly for end-of-life care. Page via switch.
- Dentist: an on-call service is provided after-hours, and in hours the Dental Clinic can be contacted. Admissions from ED are under the Oral/Maxillofacial Surgery Service.
- Drug and Alcohol: a CNC service led by **Mary-Lou White** can be contacted via the Sydney Hospital switchboard on x27111. Onsite consultation is usually available in hours Monday to Friday, and via Sydney Hospital after hours. Sydney has dedicated Drug and Alcohol beds, generally set aside for medically supervised alcohol detoxification, chiefly in those with a perceived increased risk or history of withdrawal seizures. Other services include the Gorman Unit (via St Vincent's Hospital 83821111) for medically supervised detoxification and outpatient follow-up either at Langton Clinic in Surry Hills or at POWH Outpatients.
- Hospital in the Home (HITH, also known as PACS) is available (x22470 in hours, mobile overnight) for advice or referrals for IV antibiotics at home/ aged care facility, warfarinisation (for rare instances when this is still required), and some specific rehabilitation services.
- Royal Hospital for Women relies on our ED to provide acute care, including pregnancy-related issues up to 20 weeks gestation. Many patients in these circumstances are in significant distress, and we must avoid any gaps in care. After 20 weeks most presentations, especially if clearly pregnancy-related, will be referred directly to RHW labour ward

after triage and brief medical assessment. The Gynaecology registrar is available for consultation 24 hours on page 44081. If delay is encountered please consult with senior ED staff +/- the RHW nurse manager on page 44020. A referral guideline is available on the ED SharePoint. Patients with presentations related to early-pregnancy can be followed- up in the Early Pregnancy Assessment Service.

All patients being discharged with confirmed miscarriage, and any other pregnant patient about whom you are worried, should be offered a referral to POWH social work (either directly or via the Social Work book) to ensure adequate follow-up.

- Sydney Hospital: Medical Ward referrals are made to the physician of the day (x27111). Sydney Hospital is regarded for our purposes as an outlying ward of POWH, and is particularly suited for patients who are not severely ill but need inpatient care. Full allied health services are available at Sydney. Exclusion criteria include patient refusal (please ask before referring), patients requiring subspecialty or surgical care (other than Hand Surgery or ophthalmology), and patients with behavioural disturbance or active mental health risk (there is no psychiatry onsite and less capacity than at POWH to 'special' patients.) Please discuss with senior ED staff before referring.
- Corrections Health patients: we are the designated hospital for Long Bay Gaol, which in turn is the main prison in NSW for inmates in need of complex health-care. If admitted, Corrections patients will either go to a ward with guard escort (mainly ICU or CCU) or to the Prison Annexe ward. Corrections patients are entitled to the same quality of health care as the rest of the community, but have particular needs and vulnerabilities in terms of privacy, autonomy and follow-up. Corrections Health is responsible for ongoing care at the Gaol and can be contacted to discuss further care. **Please provide discharge handover to Justice Health on 1300 076 267.** Potential delay in return (for example if chest pain recurs) should be taken into account when planning discharge.
- Hands: the hands registrar at SSEH x27111 is the primary referral point, and should be contacted to discuss care and follow-up. An EMR referral is available. On weekends, patients attending for surgery attend the SSEH hands clinic, and on weekends the usual instruction is to attend SSEH ED at 0730. There is also a POWH hands service for patients who are otherwise unsuitable for SSEH (e.g. acute mental health, in custody or acute comorbidities)
- Burns: the burns registrar at Concord Hospital should be contacted for burns requiring either transfer or specialty follow-up. Criteria for referral are available on-line. POWH plastic surgery does not generally provide a burns service, but can be contacted for advice. Some very minor burns may be accepted to the Review Clinic.

- Paediatrics: patients under 16 will be transferred to Sydney Children's Hospital. Occasionally it will be appropriate to consider SCH for a child over 16 who has not yet transited to adult services. In the rare event of a severely unwell child presenting here first, we have limited equipment for vascular access and airways. In the rare event of a birth in or near the ED, we have a 'birth pack' to stabilise, warm and dry the baby before transfer to RHW.

**Medical Workforce Unit**

**Phone:** 9382 2111

The medical Workforce Unit is able to assist you with any payroll/timesheet/ study leave queries; they are located on level 3 of the Prince of Wales Hospital High street building.

**Shift Survival Guide**

***Before your shift***

Please ensure you are well rested and nourished, as work in the ED, though it should be enjoyable, is tiring and cognitively demanding. Avoid alcohol or late nights prior to shifts. Please ensure that you have adequate time to get to work so that doctors on the previous shift can go home.

Your standard of dress and presentation should be professional and clean, and you should bear in mind the risks of body fluid or sharps exposure. Closed toe footwear is expected for this reason. Clothes should bear in mind procedural requirements, so sleeves should be able to be pushed up, and shirts/ skirts should provide adequate coverage. ED scrubs are available using the link at the end of this booklet. Surgical scrubs are also supplied as a back-up option.

During the COVID outbreak screening has been instituted at the front hospital entrance, and all staff need to complete this prior to commencing their shift.

**Jeans or other casual wear are not regarded as satisfactory.**

**PPE:**

Requirements will vary depending on the zone- please check the guidance available on the floor. Some general principles are here:

- Hand Hygiene is the most important element of any PPE strategy. Learning not to touch your face is extremely valuable.
- Droplet PPE is required for direct patient care (within 1.5m) of any patient with suspected or proven COVID.
- Airborne PPE is required for Aerosol-generating procedures.
- Surgical masks are provided for extended use for performing care for patients who may be undifferentiated in the ED. Attention to hand-hygiene, avoidance of touching, and appropriate fitting above the nose are essential.

***Starting shifts***

Shift times are: Day 0800-1800, Evening 1400-2400 and Night 2230 to 0830 (2300 to 0900 for registrars). Staff will be designated to Acute, Fast Track and EDSSU.

**Assignment to a particular work area is rostered, however during the shift, this may change at the discretion of the senior medical staff, in accordance with workflow. You may be allocated ongoing responsibility for existing patients in the department. Please ensure that you allocate yourself to these patients in FirstNet, and document the handover round in the patients' notes.**

Handover rounds will commence in Acute and Fast-Track at 0800, 1700 and 2300. It is expected that most detailed discussion and planning regarding patients will occur prior to handover taking place. For the departing night-team, it is expected that the registrar will have sufficient knowledge of each patient to conduct the acute handover while night JMOs hand over their patients in Fast-Track. For the evening shift, incoming staff should promptly attend their designated areas, and commence seeing patients, whilst also facilitating cover for any day staff who has not yet had an adequate break to do so. If a meal break is not taken, this should be recorded on the time sheet and the usual mealtime will not be deducted.

Each area will have a nursing team leader or coordinator, and you should identify yourself to him or her early in your shift.

Likewise each area/ team will have a registrar and/or consultant assigned, and you should identify yourself to them.

**Name badges, displaying your full name and role, should be clearly visible at all times. Both your hospital I.D. and your chest 'Garling' Badge should be worn. Please contact the administrative team if you need a new badge.**

***Picking up patients***

Patients are seen according to triage category, and, within triage category, are ordinarily seen in order of arrival. This is occasionally subject to specific variation under guidance from senior medical and/or nursing staff.

Triage Categories:
1: immediate resuscitation
2: life-threatening: treatment should be initiated within 10 minutes
3: treatment should be initiated within 30 minutes
4: treatment should be initiated within 60 minutes
5: generally reserved for (rare) clearly non-urgent presentations or for review clinic patients.

Please do not rely on the presence or position of paper notes for a patient as the best indicator of who is to be seen next, rather use the EMR to confirm that you are picking up the correct patient.

Please assign yourself on FirstNet to your patient as soon as you intend to pick them up, then either see the patient in the allocated treatment space, or if no

space has been allocated, you should assign a space with agreement of the Nursing Team Leader for that area.

Identification:

- Please ensure you are seeing the correct patient, that an identification wrist-band has been attached at registration/ triage, and verify that the notes you are using corresponds with the correct patient. The minimum standard identification data before initiating treatment for any patient are full name, date of birth and address. You should ask using open-ended questions: **'what is your name?' and 'what is your date of birth'**. The ED is a high risk area for mistakes, particularly where factors apply such as crowding, high-acuity, confused or intoxicated patients, 2 or more patients with similar names, and patients with limited ability to communicate in English.
- Such mistakes have the potential to be catastrophic, so please do not assume that someone else has identified your patient for you.

***Your assessment***

Ideally, your patient will have a treatment space that provides adequate monitoring, privacy, comfort and easy access to a PC to record your assessment. Unfortunately this will not always be the case, but we should take any steps we can to give our patients the best treatment space possible. If your patient has had a long wait, or conditions are crowded, please consider how you would feel in the patient's position and apologise on behalf of the ED.

Even if a patient presents with what seems to us to be a minor complaint, we must take our patients' concerns seriously and advocate for them from their point of view.

Pain management and addressing immediate stability (particularly taking note of abnormal vital signs) are your first tasks, as these issues will not always be recognised prior to you seeing the patient. (For example, patients initially assigned to Fast track may subsequently need a higher level of care).

Communication- both verbal and non-verbal, and providing regular updates to patients and their families, is the most important thing we provide for almost every patient we see.

Providing comfort, warmth, food and drink to patients, are also essential to good care, and assist good medical care enormously.

**Please be aware that everything you say may be overheard by your patient, other patients and families. Ensure that you do not make comments that**

**might be taken as critical, even in a light-hearted aside, about any patient or colleague in the ED.**

Early in your assessment, it is good practice, and expected for interns, that you should make the appropriate ED registrar or consultant aware of your patient so that any early guidance may be obtained. This particularly applies if there is any potential for:

- **Previously unsuspected COVID: in particular unexplained fever or any respiratory symptoms.**
- Instability/ abnormal vital signs. Consider sepsis, PE, arrhythmia, deteriorating conscious level.
- Possible or probable life- or limb threatening diagnosis. Beware ectopic pregnancy, acute abdomen, and compartment syndrome.
- Time critical intervention that may be needed. Consider joint relocation, fracture reduction, pain not responsive to IV morphine.

**If a patient experiences a cardiorespiratory arrest or you need urgent assistance for any reason there are red buttons at the end of every bed which, when pushed, will cause an alarm to ring. Consoles hanging from the ceiling will alert staff as to where the emergency is. All available staff should respond in the initial stages.**

**It is not uncommon for a new patient to appear well, and be assigned a relatively less urgent triage category, but subsequently deteriorate rapidly. You have a significant role in picking up cues from these patients and bringing them to the attention of senior medical and nursing staff immediately.**

<u>Supervision/ expectations</u>

The ED provides 'consultant-led' care, whereby each patient is ultimately under the care of a consultant Emergency Physician (EP). EPs are Fellows of the Australasian College for Emergency Medicine, with expertise in acute and resuscitative care, hospital and health systems, and in teaching and supervision.

Where the responsibility for decision-making is extended to non-specialist staff, the expectations are as follows:

- Registrars are doctors with at least 3 complete full-time postgraduate years of experience, who have been authorised by the consultant group to make disposition decisions and supervise junior staff independently, but to escalate risk to the consultant present or on call, or, when appropriate, to an inpatient service. Registrars are the most senior doctor in the ED from 2400 to 0800. Most registrars will be in Emergency Medicine training.

- Other 'Independent practitioners' such as nurse practitioners or physiotherapists also work within this model, and are expected to escalate issues of risk or problems outside their scope to the consultant on duty.
- Senior Resident Officers are doctors with at least 2 postgraduate years of experience, who are expected to manage most elements of assessment and disposition independently, but to have a lower threshold for discussion regarding any elements of risk. They may assist but should not supervise more junior staff.
- Junior Medical Officers.
    - PGY2 doctors must discuss every patient prior to admission or discharge, and if any change in patient condition occurs, with a registrar or consultant. Senior staff will consider whether direct review of patients is required based on risk, and will lead admission calls.
    - PGY1 doctors must similarly discuss every patient. Senior staff should provide at least brief assessment of every patient, and will conduct admission calls.
- Where decision-making has been shared with a supervisor (and/ or inpatient team), the names and contribution to care must be clearly documented, including when elements of supervision pass from one doctor to another.

<u>Some tips for junior doctors:</u>

- 'front-loaded' co-assessment with a senior doctor is encouraged as it is an excellent training opportunity and is good both for patient care and ED flow. The sooner
- Forming an active partnership with your supervisor: you may assist e.g. by charting medications or taking bloods for his or her patient, to free up time for him or her to see you patient. Come to your supervisor early, but make the effort to formulate a coherent working diagnosis and plan to test with him or her.

**Differential Diagnosis:**

- **This is a very important aspect of safe decision-making.**
- Your **working diagnosis** should be a summary of what is likely to be the main problem.
- Your **differential diagnoses** should structure important additional or alternative diagnoses, in particular serious ones, with reference to positives or negatives from your assessment and investigations.
- **As a general rule we need to consider the worst and think back.**

***INTERPRETERS***

**The interpreter service should be used for all non-English-speaking patients. In an emergency a member of staff may be used, however use of friends or family members is discouraged and should be reserved for lower-risk (or urgent) circumstances.**

Please take note of referrals, past notes, and any indicators that your patient may be at higher risk for a poor outcome than you would otherwise expect. Please do not ignore your own judgement and experience- you may well have obtained details or concerns that a more senior doctor has missed. A good suggestion is to consider the 'clinical bottom line' for each patient, which may vary depending on what the patient's particular concerns are, what you feel the patient needs, and also on what other people such as relatives or other doctors have suggested the patient needs.

Please consider social safety: this includes risk of fall or other misadventure, risk of assault or neglect of the patient, and occasionally risk to others. **Always consider whether your patient has dependents (children, disabled partners, even animals)** and their safety and welfare both while the patient is in hospital and on discharge. **If there are children at risk you will need to consider and obtain advice on Community Services notification.** Consider if there are any activities that would pose a particular risk to the patient or others, e.g. driving, flying, safety at work, even risk of assault. Particular rules or legislation may mandate notification to third parties.

**Beware the possibility of an atypical presentation of a serious diagnosis. Unexpected deaths after ED discharge have been associated with 3 main factors[1]:**

- **Atypical presentation of a serious diagnosis, such as sepsis, cardiac disease, pulmonary embolism, early neurological emergency.**
- **Decompensation of chronic disease.**
- **Impaired ability to return to the ED if deterioration occurs. This group includes the elderly living alone, mentally ill patients, patients with substance dependence, and patients with other constraints on their choice on return such as correctional inmates.**

Some particular note needs to be made of risk management prior to discharge.

- Abdominal Pain: we expect registrar or consultant involvement, especially if morphine has been given or in the elderly. All females of reproductive age with abdominal pain should have serum HCG as ectopic pregnancy can be insidious. An Abdominal and Loin Pain Guideline is available on the ED SharePoint.
- Chest pain: all ECGs are assessed and electronically signed by a registrar or consultant, principally to screen for ST elevation syndromes. If you see an unsigned ECG, please bring it to senior attention immediately. Once

you have commenced an assessment, please discuss, ideally with the same senior doctor, to allow clinical correlation. The NSW pathway for Acute Coronary Syndrome Assessment (PACSA) is available on the ED SharePoint and ECI website. The POWH STEMI pathway is available on the ED SharePoint.

- Headache: all patients with undifferentiated and unresolved headache require consultant (generally ED or neurology) assessment. It is not safe to diagnose a primary or self-limiting headache syndrome unless your patient has had similar headaches before. There are a number of important rare but important diagnoses which require risk-assessment prior to discharge. The SESLHD Headache Guideline is available on the ED Sharepoint.
- Pulmonary Embolus: this is a differential diagnosis for a wide range of patients with shortness of breath, syncope, and/ or chest pain. Consider whether your patient reaches threshold for structured investigation. A summary of investigation pathways are found on the ECI website.
- Acute testicular pain: consider torsion until a clear alternative diagnosis has been identified. Notify a senior doctor immediately.
- Complex infections:
    - Diabetic foot infections: are always discussed with Infectious Diseases prior to contemplating discharge. Admission is usually required, normally jointly with a surgical team. Please do not refer to HITH without referring as above.
    - Infected joints/ orthopaedic hardware/ suspected spine infections: are always discussed with the relevant surgical team prior to antibiotics.
- Spinal patients: the spinal (medicine) team is to be informed of all long-term spinal patients who require admission (so that an appropriate bed can be arranged) or who have a spinal medicine-related presentation.
- Renal/ dialysis patients: the renal team is to be informed of all dialysis (or pre-dialysis) patients who present to the ED.

**Some work tips:**

- Try to structure your consult to maximise efficiency and front-loaded decision making. If a patient clearly needs admission then many investigations can be deferred to the admitting team; ED senior staff should be involved to get that patient admitted. If a patient is likely to need a particular investigation to decide ongoing care, then efforts to organise that test earlier rather than later will be very worthwhile.
- The number of patients a doctor will see in a shift will vary depending on the patient, seniority and experience of the doctor, and the overall environment in the ED that day. If you feel you are having difficulty progressing though sufficient patients, or progressing to the point where you can comfortably pick up a new patient while other patients

are still in process, please discuss with a senior colleague. Many of us will have tips that could work for you.
- Junior Medical Staff in Fast-track/ Subacute: if an NP or Physiotherapy practitioner is on duty, please check with them before picking up a patient within their scope. They may be overloaded and welcome your assistance, or you may be better placed to pick up a different patient.

***Documentation***

Clinical notes, both by ED and non-ED staff, should be typed into FirstNet, as contemporaneously as possible. Handwritten notes are only to be used in the event of EMR outage. **All notes should be signed at the first possible opportunity to avoid them being reassigned to another staff-member. Where notes are the product of joint assessment this should be made clear.**

The recommended Clinical documentation formats for medical staff are 'Adult Exam ED' and 'Discharge Referral ED', with the particular pre-completed title 'POW ED- Medical'. A Discharge Referral is required for patients going home, and will be faxed electronically to your patient's nominated GP. Please ensure you have been shown how to use these formats at the start of your term. 'Progress note' is not recommended for initial medical assessment.

Please take care with confidentiality and safety. In particular:
- Check that letters are documents you give patients do not include pages meant for someone else.
- Avoid taking documents with patient-related information out of the ED: confidential information falling on the street on into non-secure rubbish streams severely undermines community trust in the hospital.

**Diagnosis:** please enter a diagnosis for all patients seen. This has important implications for funding in the ED and EDSSU

Many patients do not need investigations. History and examination are often sufficient to guide care, and many investigations can safely and wisely be deferred to the patient's own GP.

Documentation standards:
There is a tension between the need to document succinctly and quickly, as opposed to recording every piece of information obtained. ED documentation is oriented clearly to the goal of safe disposition and handover of care from the ED.
Some rules of thumb are:

1. Document for your patient (and their family), and assume they will read everything you write. Avoid tone or expressions which appear critical or which may undermine the therapeutic alliance. Specific terms to avoid include 'denies', 'claims', 'alleges', 'non-compliant'. Please also avoid

comments or which are critical of other practitioners. Even mild comments are easily taken out of context.
2. Do the basics well: pain history, medication lists (with dose, time and compliance/ currency documented), and relevant social history.
3. Ensure your diagnosis is clear and supported by facts. It is likely to evolve as more information becomes available. Record differential diagnoses and relevant negatives as outlined above.
4. Weight your documentation to disposition, diagnosis and plan; documenting this (and discussing with your seniors) well and early is the most effective way for you to target your efforts.
5. Record by name and time those with whom you have consulted or shared decisions with. This includes GP, inpatient consulting team members, ED senior staff and the patient/ relatives.
6. Integrate your assessment intelligently with all the other information at hand. Make note of triage/ nursing/ admitting team/ ambulance comments, and if your assessment is different in any significant respect from any of these please indicate your reasons.

***Correct Patient, Correct Side, Correct Procedure:***
Significant risk can arise whenever we commence investigation or treatment. Explicit, out-loud checking practices can prevent errors.

- Correct patient: label all bloods correctly, take care when ordering on EMR that the correct patient's file is open, ensure that your patient knows what x-ray they are having.
- Correct Side/ Correct procedure: take care when identifying a side for x-ray or procedure, or when describing a side to others who may rely on information we give.

***<u>Investigations/ imaging</u>***

The ED should only investigate testing if it will genuinely change what we do. There is a role for commencing some investigations on behalf of admitting teams, but if a patient needs admission on clinical grounds, the results of these should not delay admission.

***<u>Results Follow-up</u>***

If a positive blood culture or clearly unexpected imaging abnormality is noted on an ED patient who is subsequently discharged, the ED will generally receive a call from the lab/ reporting room advising us to follow that patient up. For other results (generally urine cultures and serology testing) the ED may not receive this result for some time, and follow-up systems are currently very unreliable. **Please specify in your letter <u>which</u> antibiotic has been prescribed, as resistant organisms are common. In the ED we expect all doctors to endorse all results in their EMR Message Centre regularly.**

A difficult or unexpected result should be discussed with a senior doctor prior to endorsement, as there is no means of recovering a result from the system. JMOs will normally be asked to focus on their own Message Centre, but may be asked to help work from the ED 'pool' under senior supervision.
On day shift please speak to the consultant on duty for EDSSU, otherwise the consultant on duty can be contacted for any complex or unresolved issues.
**If you perform active follow-up for a patient (i.e. phone, call back to ED, call GP, fax, mail or email copies etc.) please open the discharge referral in 'documentation' tab, and make an addendum detailing your actions and instructions. This will prevent subsequent doctors seeing the same report and making the same attempts to follow-up.**
**Follow-up on abnormal or unexpected results remains our responsibility until we know that our duty of care has been discharged.**
Biopsies, serology testing, endocrine testing, autoimmune testing and similar tests can generate not only cost to the ED but also significant clinical and medico-legal risk. In our ED, if you are considering or have been advised by a non-ED team to do a test that would fall under such a category, you must discuss it with a registrar or consultant and make a clear record regarding approval and follow-up in EMR. **Such tests should generally be ordered only if a requesting team is unambiguously taking on responsibility for follow-up. If entrusting follow-up to a GP, then merely advising a patient, even in a letter, may not be enough. A call, documented in EMR, specifically noting GP acceptance of that responsibility, may be needed.**
Imaging reports in particular are subject to change, and the EMR does not itself keep a version history, so please bear in mind that you could be sending a patient home with a normal report that could change to an abnormal one. **The default instruction should be that all patients should seek the final report via their GP**. If you are not 100% certain the X-ray showed no fracture, splint the injured part, provide analgesia, and send the patient to the next fracture clinic.
Imaging can be ordered on FirstNet, with most plain radiology available in the ED X-ray suite 24 hours a day (mobile CXRs can be done in resuscitation bays and beds 8-12), and CT (x20333)/ ultrasound (x20353)/ MRI available in the radiology department nearby.
**Clinical information is very important for subsequent evaluation and is best entered in the 'reason for exam' section of the FirstNet order screen.**
Nuclear medicine is available on level 2- not suitable if your patient is unstable. Venous Doppler is performed at the Ultrasound department (x20353) within POW Medical Imaging. Gynaecological ultrasound is available at RHW (x26080) and can be ordered by any ED doctor, after discussion with senior ED staff to ensure it is required, without the need for prior consultation with the on-call gynaecology registrar. Imaging outside the ED generally needs a phone call (or page after hours) to confirm/ discuss after ordering on FirstNet.

**Transfusion** is a particularly important area to get right, as it has significant resource (both blood bank and ED workload) and safety issues.

**Group and Save requests need to be printed and signed (by the collector), and sent with the correct hand-printed tube to Blood bank. Clerical errors are unfortunately very common in our ED and each one is logged as an incident by Blood Bank, requiring full sample re-collection. Please take a 'time-out', ideally with your patient, to check every detail: spelling, dates, identity. 'Wrong blood in tube' incidents are potentially fatal, and all steps to avoid them should be taken. Always maintain sight of blood from point of exit from your patient to completion of tube details. Recollect if it has left your sight. Never handle more than one blood-bank tube at a time and never hold on to blood bank tubes 'just in case'. The sample should be collected and sent at the time it is to be ordered or sent.**

Cross match requests should only be sent when cross-matched products are required. When blood is ready a pink requisition should be sent. The same pink form should also be sent for other blood products (plasma, platelets, anti-D etc). Type O blood (O negative for females of childbearing age) is available as a 'Trauma pack' is required super-urgently. Guidelines for transfusion and blood product replacement are available on the Sharedrive and Hospital Intranet. Administration of blood products requires specific consent and administration forms, including a specific for Anti-D administration (250 iU for first trimester, 625 iU for 12 weeks onward).

**NB current unit availability can be found in the 'Patient Product Enquiry' link from Firstnet, not on the EMR Flowsheet.** Mandatory training includes 'Blood Safe': please ensure you have completed the current module.

Please minimise transfusions in the ED, bearing in mind appropriate indications and haemoglobin levels and deferring them whenever possible to inpatient teams in hours. All consent requirements must be adhered to, with forms available around the department- both the general blood product form and the specific one for Anti-D. Single unit transfusions are recommended when appropriate for symptom management- and admission under the appropriate team is required if larger transfusions are planned. Iron infusions may be an alternative or additional option. **Admission under an inpatient team is expected if more than one unit is planned.** The POWH Ambulatory Care Unit can take referrals for non-urgent outpatient transfusions and infusions.

***Completion of care***

Once your initial assessment is complete, you will need to make a plan, under supervision, for further management and disposition. All referrals external to ED should be discussed and approved by senior ED staff before they are made.

**Under the Emergency Treatment Performance (ETP) target, all EDs are required to keep time from arrival to departure within four hours, so efficient decision-making and communication at this point is vital.**

- **2:1:1 means that key disposition decisions should be made within 2 hours, an appropriate admitting team arranged by 3 hours and transfer to ward should be complete by 4 hours.**

**Most contact with an inpatient consultant or team regarding a patient will constitute a 'decision to admit' which should be recorded on 'events' in FirstNet.**

**You should communicate with the patient throughout, not only regarding diagnosis and treatment, but also regarding where he or she is in the ED process.**

**Medications**

Medications (both regular and PRN) should be sufficiently reconciled and charted on eMeds, to ensure adequate care until team review. **Please follow the steps 'Document medications by history' and then 'Admission Reconciliation' for all patients who take or who will be commenced on regular medications.** Please check 'First Dose' timing carefully to ensure appropriateness. 'Add order' should be used for stat/ single dose medications only. Pay particular care when interpreting lists on transfer letters, which may be incomplete or contain superseded medications. Checking medications, dosage, interval and compliance with at least 2 sources, one of which should be directly with patient or carer, is the standard expected. Please be aware of high-risk medications (e.g. methotrexate) and combinations (e.g. beta-blockers plus calcium channel blockers, NSAID plus ACE inhibitors). Check and chart insulin carefully; all insulin-dependent patients need at least long-acting insulin, even when fasting. Guidelines are available on the Sharepoint and POWH policies page for fasting patients. Consult endocrinology if in doubt. Please ensure that any order to start or stop a specific medication is reflected in the chart. Please use the charting stage to double-check that any medication charted is appropriate- e.g. suspend metformin if IV contrast is to be administered or in acute kidney injury, suspend potassium if hyperkalaemic, suspend antihypertensives if at risk of hypotension, **ensure methotrexate is charted WEEKLY not daily**, ensure that transdermal patches are correctly prescribed including date of next patch change, ensure methadone paperwork is completed and dosing history obtained from provider.

Please ensure that discharge documentation reflects medications being taken on discharge.

**Antibiotics**

In order to reduce inappropriate prescribing of antimicrobials (and consequent rates of multiresistant organisms) the hospital has a system of antimicrobial stewardship. 'Orange' antimicrobials should have appropriate approval numbers obtained via the **'MS Guidance'** tab from FirstNet and

entered on eMeds. “Red” antimicrobials should have approval from the Infectious Diseases team.
Our antimicrobial choices overall should closely follow current recommendations in eTGs, except where a more specific hospital guideline (e.g. Initial Management of Febrile Neutropaenia) is available.

***Admission***

If your patient is to be admitted, then one or more of the following will happen:

- Default, and currently expected in hours: ED senior (see below) to admitting consultant or delegate. Medications sufficient for immediate needs should be charted.
- **The admission principle is ‘Call equals disposition’. Disposition decisions may include consideration of EDSSU (+/- team review there) if otherwise appropriate, discharge with an appropriate follow-up plan, or admission under an alternative team. While the ED may assist with a call to an alternative team, patients requiring admission are allocated under the first team referred, which carries primary responsibility for arranging transfer of care.**
- ED senior means consultant, registrar, or after discussion with a more senior doctor, ED SRMO call to consultant. On occasion an intern or PGY2 doctor may wish to participate in an admission call, but you must ensure that their patient has also been seen by a more senior doctor who is able to take over the call if needed.
- Registrars are first call for surgical specialties, gastroenterology and dermatology (24 hours), and during normal working hours for most medical specialties. A detailed call sheet is available in the clinical areas. If any delay or difficulty is encountered the on-call consultant should be contacted.
- Medical registrar review:
    - In-hours, the team registrar is the approved AMO delegate.
    - The call to any registrar should be as for admitting calls above. Transfer to an inpatient bed should not be delayed.
    - Out of hours we page the ward medical registrar either for assistance with the admission process or if requested by the AMO.

The JMO role in these situations is to ensure EMR documentation is correct and complete, that any medications needed are charted (please check to make sure your charts are consistent with senior plan) and that all ongoing treatment (fluids, transfusion etc.) is correctly written up. Outstanding results or tasks are handed over either to the admitting team in hours or to after-hours ward-cover. **Please also be aware that if a patient appears to deteriorate while awaiting either inpatient team review or transfer to a ward, that you need to notify senior ED medical staff. Patient care remain the responsibility of the ED until they have left the department**.

***CONSENTS***
The team or doctor planning to do a procedure should obtain the consent. Generally it is not possible for you to adequately obtain informed consent from the patient. Other than for blood products, or, when specifically guided by supervising ED medical staff for procedures in and by ED, JMOs are not expected to obtain consents.

***Discharge***
If your patient is to be discharged, a number of general requirements should be met.

- **No patient should be discharged unless they are reasonably expected to get to and manage in their home environment, either alone or with available assistance.**
- Patients should have a clear understanding of their diagnosis, treatment recommended, prompts for return and plan for follow-up.
- If you are advised to discharge a patient and you are not convinced that it is appropriate, discuss it with the ED consultant, particularly if the decision has been made without the advising doctor (whether ED or inpatient specialty) seeing the patient. EDSSU may be an appropriate option, especially after hours.
- **A patient who has visited the ED more than once for the same or related problems should be discussed carefully with senior staff, with this discussion documented, with a very low threshold for personal senior review. There may be complex reasons for failure of a single ED visit to deal with such patients' problems, and potential for senior review to have a significant impact. There may also be significant clinical and departmental risk associated with discharge without such review.**

A default rule, which can be tailored to individual circumstances, is that all patients should see their GP after an ED visit. The patient should have a safe means of getting home, preferably with a carer to assist them. A number of options for transport can be arranged if needed- please discuss with senior staff or, in elderly patients, with ASET. **Elderly patients should not generally be sent home without capable care after dark.**
A similar handover of care to that given to inpatient teams is needed for the patient's GP. **If the discharge decision is contrary to the expectations in the GP referral letter, then a phone call to the GP is usually a good idea to discuss options or to explain the outcome of attendance.**
A letter should be provided for every patient unless specific reasons exist for not doing so. It should contain, at minimum[3]:

- Your name and the names of any other doctors who had significant involvement. It should name any inpatient team representative consulted.
- History and examination. In many cases this may be your clinical notes.

- Investigations performed and results, and if applicable, details of outstanding results. Please note that EMR-generated documentation may be incomplete in this regard.
- Assessment / problem list including Differential Diagnoses considered.
- Plan of management

Share and explain the contents of the letter with your patient. Having your patient share in the details of discharge is a powerful way of engaging him or her (and family) in responsibility for ongoing care and follow-up, in identifying areas of uncertainty, and in ensuring clear 'safety net' instructions in case of deterioration.

If bloods have been taken these should be loaded into the letter via FirstNet (or at least printed out separately if this has not been possible), and if other investigations such as ECG are relevant to care, they should be copied and enclosed.

**Your letter may also be structured as a referral to outpatient clinic or specialist, in which case it should contain a valid Medicare Provider Number**

**Discharge diagnosis**

It is the medical officer's responsibility to ensure that each patient has a diagnosis and time of departure entered prior to leaving the ED, whether to home, EDSSU or the wards. The most efficient and consistent way to do this is by the 'Depart Process' tab on FirstNet.

***Outpatient follow-up***

Appointments can be made on-line for fracture clinic, general orthopaedics and plastic surgery by notifying clerical staff. A form with current details is kept on Sharepoint and in Fast-track. A letter with appointment details will be provided for the patient.

ENT and urology clinics can also be booked but require a faxed letter- see clerical staff.

Please check first who is on for hand injuries (alternately orthopaedics and plastics) before referring.

Plastic surgery clinic every Wednesday morning requires authorisation from the on-call registrar.

Early pregnancy clinic appointments must be made directly (0730 to about 3pm) or via the RHW nursing manager (page 44020.)

Other clinics can be booked via x20400. Less urgent referrals can be faxed to OPD (check number with front desk). Any particular arrangements (e.g. booked assessment in a ward or office) should be clarified with the specialty team, and adequate contact details exchanged.

***Work certificates***

Don't forget to ask the patient if they need one before you send them home. Always ask if it was work related or happened on the way to or from work, and

if yes, fill out the Workers Compensation form. Otherwise, use the hospital 'work certificate'. Please ensure that all relevant information is included, that items not required are crossed out, and the duplicate is enclosed in the paper medical record. An attendance certificate can be provided to carers.

***Blood alcohol samples***

Blood alcohol levels are required by law to be taken from persons 15 years of age and above who attend a hospital as a consequence of a motor vehicle accident on a public road or 'road-related area'. Samples must be taken from the driver of the motor vehicle; the occupier of the driver's seat attempting to put it into motion; a pedestrian hit by a motor vehicle; a person driving or riding a non-motorised vehicle or horse involved in an accident, a licensed person supervising an L-plate driver. A sample is not required if the person is a passenger or attends hospital more than 12 hours after the accident. The procedure and reasons for it should be explained, and if a person refuses to submit to blood sampling record this in the notes and advise the police, who will generally attend. Record the sample number in the medical record. A special kit is available and must be used. The sample and complete paperwork should be placed in the locked bin which you will be shown.

It is permissible for nursing staff to take the blood. If the sample is not taken you, as the treating doctor can be prosecuted and fined heavily.

The police may also, on occasion, bring someone in for drug testing after a crash. There are separate kits for this, as urine also has to be collected. Instructions are in the kits.

***<u>Discharges against Advice/ Did not wait</u>***

Both of these groups of patients represent a failure of service. The most common feature associated with either group is long waiting times, either to be seen or for definitive care once seen. Such delays are not always preventable, but should be actively monitored.

Patients should feel free to leave if they wish, but the following basic requirements need to be met:

- The patient must have general capacity to understand their choice, and must have any specific information relevant to them about their likely diagnosis to assess their own risk of coming to harm. This is obviously difficult if a patient has not been seen, and places significant onus on us, for example if intoxication or head injury is suspected or if an investigation (bloods or x-ray) has been ordered at triage.
- There must not be a legal obligation to detain or treat a patient involuntarily, either under the Mental Health Act, or under 'Duty of Care' provisions to prevent significant harm to a patient lacking capacity. Please again beware intoxicated or possibly head-injured patients, as well as those who are dependent on others to decide their own best interest.

If in any doubt, please ask for support from senior staff.

***Variations in advice***

One thing you will notice in ED, as in the rest of medicine, is that advice may vary depending on which senior doctor you speak to. The ED sees patients at their most dynamic and least differentiated, and it is hardly surprising that there may be more than one valid way to treat a patient. Emergency care is not about finding **the one best** way to treat a patient, but about finding **a** good, effective and efficient way to negotiate care between ourselves, community providers, inpatient resources and the patient (ethically balanced with the needs of other patients). Seeing different styles and approaches in this light is an important part of training.

Some general rules of thumb:

- Management advice will be much more consistent and effective if the senior doctor giving advice has also seen your patient. You should have a low threshold for asking for this review.
- For one patient, seek advice from one consultant or registrar. Please try not to 'doctor shop', as it can create mistrust and undermine patient confidence. If you are uncertain or concerned about advice you have received, in the first instance discuss those concerns with the senior doctor involved. If that fails to resolve the problem, you may wish to seek guidance from another trusted senior member of staff.
- If the initial doctor is not available when something has changed or a new question arises, please let the second doctor know what advice was received from the first.
- Always discuss with the ED senior before referring to inpatient teams. We have responsibility for patients while they are in the ED, as well as priorities based on our patients' presence in ED rather than in that team's clinic or ward. While we value expertise and support from others, it is up to us when to seek and what to do with that advice.
- If a plan changes, for example on the handover round, do not take it as a personal reflection. It is simply the nature of ED.

## ***Mental Health***

The Mental Health team is available 24 hours.

No patient who has an acute psychiatric illness should leave the ED until they have been discussed with psychiatry.

All patients expressing or who have evidence of recent suicidal ideation are to be seen by psychiatry. They should receive a psychosocial assessment by attending medical staff, as well as care for any physical/medical concerns, and referral to the Mental Health Team. If there is any doubt about such referral, if the patient wishes to leave and there is any doubt as to whether the risk of harm justifies involuntary assessment, or the team is not available to discuss the patient, please seek senior advice urgently.

Medical co-assessment will be requested if the MH team identifies medical or other issues which might make admission to a mental health unit unsafe. Important acute diagnoses include delirium, specific neurological illness such as encephalitis, or illness/ injury which may have been neglected in the context of poor mental health or social supports. Such a screen does not equate to an extended psychosis screen, nor does it guarantee that there is no organic illness present. If vital signs are normal and no physical symptoms are expressed, it may not require any tests at all. It does not routinely include urine drug testing- this has complex ethical ramifications and is only ordered by ED staff in very specific circumstances. If in doubt about any aspect please discuss with senior ED medical staff.

Please consider the need for schedule under the Mental Health Act. At the ED level this is a safety assessment about whether a patient could foreseeably come to or cause harm if he or she left without being seen by Mental Health. Please consult if in any doubt. **If a patient absconds while under schedule we need to notify police and security immediately with a description.**

If you are caring for a patient whom you anticipate will need mental health admission but who has not been admitted or is awaiting second or subsequent review, please ensure senior ED medical staff are aware so that any elements of risk and delay are managed.

The Mental Health team should be aware of any patient being considered for emergency sedation.

The Mental Health service will endeavour to streamline entry to the Psychiatric Emergency Care Centre (PECC) or other inpatient units at the earliest possible safe time. Where appropriate the ED will provide in-reach to PECC to avoid any gaps in care where residual medical issues remain or where Mental Health assessment is incomplete.

***EDSSU admissions***

The EDSSU is used for patients admitted under the Emergency Consultant, who are expected to be discharged within 24 hours. Examples of suitable patient include patients with mild head injury undergoing neurological observation, renal colic awaiting scan and/ or response to analgesia, patients accepted for care at other hospitals awaiting transport, and elderly patients not safe for discharge at night. Admission needs to be approved by senior ED medical staff, with a plan documented and medications charted. Other teams may not admit to the EDSSU, with the exception of toxicology. Admission to EDSSU for team review will be considered for patients who are likely to be discharged, and subject to other demands on the unit. The key EDSSU exclusion criteria are: likely subsequent inpatient admission, and involuntary status under the Mental Health Act (unless specifically agreed to after appropriate risk-assessment or staff adjustment). An EDSSU Draft business Rule is located on the ED SharePoint.

## Violence and Aggression

Safety for both staff and patients is paramount, and the ED is an environment where a range of factors can lead to escalated behaviour, and where a range of risks relating to security in general exist. Some of these factors come with the patient, such as acute mental health problems, acute intoxication, and some are modifiable, such as long waits to be seen, and stimulation from other patients or staff. **If you are involved in an escalating situation, please involve senior staff immediately**. Duress phones should be used, and please pay attention to your own ability to get out of the patient's immediate environment, and be aware of any articles either on you or in the environment which might be used as weapons. De-escalation, in particular by listening to and acknowledging concerns, and where appropriate by strategies including moving to a safer environment or offering voluntary anxiolytic medications, are the key to safe management and avoidance of compounding trauma to the patient. Restraint is dangerous both to patient and staff, and should only be attempted by staff who have undergone appropriate training such as the EDVPM program. On occasion it may be safer to let an agitated patient leave. If a patient has departed in circumstances where they are either under the Mental Health Act or, by so doing, now need to be, the Clinical Nurse Manager will assist with notification to Maroubra Police including a faxed description and risk assessment.

***Communications Clerk***

We have a Communications Clerk, with duty hours 0800 to 2300 7 days a week, to assist with paging, putting through calls, finding staff and updating patient details.

The daily on-call sheet is a useful guide to who is carrying call for the various specialties.

***Phone Calls***

Admission or advice calls should not be taken by JMOs but handed on to the admitting doctor for the day, usually the EDSSU consultant. If you receive a call relating to a patient you know or have discharged, seek supervision as you would were the patient present.

Ambulance notification **'Bat-Calls'** are received on a dedicated phone on the bridge. Answer immediately, write down the information given including time of call and estimated time of arrival, and tell senior staff immediately.

***Handover***

Whenever possible please discuss your patients with and make your referrals **before** each shift handover.

Consultant-supervised handover is a very important process in ED, as many patients will require care from many staff across shift transitions and thing can change rapidly. The acute round is at the bedside and, where appropriate, will involve patients or their representative by clarifying what is happening and who will be taking continued care.

Our handover processes, particularly at shift transition, emphasise succinct but effective and predictable transfer of responsibility and care[4]. Learning to summarise a patient's presenting complaint, diagnosis, differentials, plan and outstanding items efficiently is an important and satisfying skill. **ISBAR**, adapted slightly to an ED environment, is the expected standard across NSW Hospitals and is a good structure for remaining focussed on those issues and helping the receiving doctor take on care safely:

- **Introduction-** patient name and location (if unclear)
- **Situation**: Presenting symptom- e.g. chest pain
- **Background**: Only as relevant to current care- e.g. Known IHD, renal impairment with creatinine baseline 150.
- **Assessment:** Diagnosis, stability, any serious differentials under consideration.
- **Recommendation*:*** Disposition, tasks pending- e.g. admitted cardiology, 2nd troponin at 8 pm, has bed on CCU.

Patients should be assigned to and handovers documented by the incoming JMO[4], ideally as an addendum on EMR documentation.

The other occasions of handover include receiving care from ambulance or other external staff, and handing care on to ward staff once admitted. Although the formalities are different, the principles should be the same. **Patients leaving the ED should have plans clearly documented in the electronic notes, and if outstanding tasks or potential instability exist, then the onus is on us inform covering medical officer(s), particularly after hours.**

**Handover to wards:**
Please consider carefully whether your patient has decisions pending or is at risk of deterioration on transfer to the wards where monitoring and staffing may not be as intensive as in the ED, in particular after-hours. Be particularly mindful of concerns expressed by nursing staff. Escalate any evolving issues to senior medical staff. **Use the 'ED to ward handover' form for patients who may need after-hours attention and tick the 'Add to Census Task List' option.** This list will be used at the 16.30 and 22.30 inpatient handover meetings. When placing a patient on this list you will be reminded to call the relevant staff-member (usually the Medical Officer in Charge- 'MOIC') to ensure that your handover is received and to give the opportunity for check-back of information.

## ***End of Shift***

Following handover, it should ordinarily be possible to depart by the end of shift. Tasks that were identified at handover but are yet incomplete can usually be tasked to doctors on the next shift. On some occasions, usually related to finalising care for a particular patient, it is recognised that this is not possible, and unrostered overtime should be claimed. The main proviso for this is that the senior doctor on duty for the ED needs to be aware and approve of this before

the time is worked. Overtime can then be claimed for signing by athe ED Director prior to the next timesheet.

***Timesheets/Rostering.***

The roster is emailed 2 weeks prior to the start of term, and the current version is available on all PCs in the ED. **You will be expected to know and be available for all your shifts as they appear on the roster, including any on-call that may apply.** Shifts are rostered as equitably as possible across days, evenings and nights, across the week. Swaps need to take into account both service provision and fatigue-management. They need to be requested by email to Adrianne Love. Please ensure Dr Murphy is aware of any difficulties early.

Please do not consider a change approved until it appears on the current roster. Please check the roster frequently for any changes- we will always try to advise you of any swaps affecting you- but mistakes will occur and we're happy to correct them. Please advise us of any sick or other absence as early as possible, so that we can try and arrange cover. Please notify of any difficulties or special circumstances that may affect your welfare or your ability to perform your duties as early as possible.

Non-attendance, or late arrival, to a shift without appropriate approval, is a serious failure of professionalism. If any circumstance threatens to prevent you from attending work you must contact the department immediately. Do not rely on others to pass this information on, and do not rely on phone messages or texts. If the ED Medical Workforce Coordinator (93823839) is not available then please contact the floor (93828400/ 93823960) to notify the duty consultant. Please email Adrianne Love Adrianne.Love@health.nsw.gov.au Cc. Judith Lissing Judith.Lissing@health.nsw.gov.au to update rosters and timesheets.

Timesheets are to be signed fortnightly and are prepared in the Medical Workforce Unit. It is very important that the roster correctly reflects time worked/ leave claimed each fortnight, as it is used to generate your timesheet.

It is also very important that if you are employed full-time your hours (shifts, leave and ADOs) add up to at least (and ideally not more than) 80. You can expect to be rostered for approximately 2 ADOs over a 10-week term, and if you have several ADOs accrued and need to claim a 3rd please let us know. ADOs can also be claimed during periods of planned leave—check with the JMO office if in doubt. The ED will endeavour to keep overtime to a minimum, both for fatigue management and to help the hospital manage budget responsibly, but reasonable overtime (generally up to 1 full shift over a fortnight) can be rostered. Please let us know if difficulties arise.

***Night Shifts:***

Ensure you are well rested prior to and between night shifts by developing a routine that works for you. Some tips include:

-Avoid caffeine or alcohol before sleep

-Plan meals and try to eat healthy, enjoyable food
-Try to darken the room/ damp out external noise. Routines like a shower or something simple that prompts your body that it is sleep time can be useful.
-Go to bed when you have wound down and are ready for sleep, try to avoid distractions once in bed (such as TV etc).
-Exercise after waking rather than before sleep
-Plan a time of day when you can interact with friends or loved ones, and plan something special to look forward to after nights.
-A final 'power nap' prior to the shift can really help!

***Leave***

***Annual/ Study (for registrars/ SRMOs) –*** to apply for annual leave please contact Adrianne Love and complete a leave application form/ supporting course paperwork as early as possible prior to the commencement of term. Priority is given to ACEM Primary Examinations. You will be notified once your leave has been approved.

***Sick –*** if you are calling in sick please talk to the consultant in charge on the floor by calling the bridge on 9382 8400. We will notify the Medical Workforce Unit for adjustment to your timesheet. If you are sick for three or more days consecutively you need to provide the ED office with a medical certificate.

***Teaching***

The ED places a high value on teaching, both formally and on the floor. On the floor teaching is an active process, with every patient providing opportunities to learn. Formal teaching is as follows:

- Interns: Tuesdays 8-10 on alternate weeks. All interns should find themselves rostered to attend in the ED conference room. Coordinator: Sarah Gollance.
- PGY2: Usually Tuesday (occasionally Thursday) on alternate weeks. All PGY 2 staff rostered. Coordinator: Claire Leonard.
- SRMOs: are invited to registrar teaching on Wednesdays if available.
- The ED will have a number of Medical and Nursing Students assigned, so please help them feel welcome and supported.

***Assessment/ performance***

The term supervisors for 2020 are:

- Sarah Gollance (PGY1)
- Claire Leonard (PGY2)
- Joanne Short (SRMO)
- The ACEM Directors of Training are Kate Sellors and Therese Becker.

Please contact them, and/or David Murphy, if you are having any difficulties throughout the term. Consolidated feedback will be obtained from all the consultants at mid- and end of term. If you feel at any time that you are having problems, please feel free to approach any of the staff specialists for help or advice.

*Avoiding complaints*

Treat patients and their relatives, as you would want yourself or your family to be treated. This includes limiting waiting times as much as possible for patients waiting to be seen, maintaining confidentiality of patients you treat, and involving them respectfully in discussions and plans regarding their care.

**Most of the complaints received by the ED result from problems in communication. Talk to your patients frequently. Explain what is happening to them; what you think is wrong with them and what they are waiting for.** Reassure them that you are doing everything you can but some things are outside your control. Apologise for delays if necessary, even though you may not personally be responsible: remember, you are a spokesperson for the whole department. Involve your patients in decisions relating to their care, including triggers to return, areas of uncertainty relating to diagnosis, or where 2 or more valid treatment options might be considered.

**Another area of complaint revolves around pain - do everything you can to relieve your patient's pain**. Carefully titrated narcotics, despite a traditional concern that this might be a risk, do not mask peritonitis. If the patient turns out to be a drug seeker, don't worry about it - you'll recognise them the next time. Patients with opiate tolerance require special care and early senior review to ensure adequate analgesia. Splint fractures - don't leave them waving in the breeze. **These issues can sometimes be a problem shortly prior to shift changeover, and even if the main clinical assessment can be safely deferred to the oncoming shift, some initial analgesia and exclusion of life/ limb threats is important.**

Give early, effective pain relief, preferably via fast acting, titratable routes (IV or inhalational) for severe pain; don't forget paracetamol for mild pain. Check with the patient that the pain has resolved; if not, more analgesia may be required. A guideline to pain management is on the department share drive.

## ***Fatigue/ Stress***

ED is a tiring term, even though overtime is generally minimal, both because of the nature of the work we do and because of the disturbance shift-work causes to our natural daily pattern. All the senior staff in the ED have experience of this stress and fatigue over many years, and will try to support you.

The up-sides are days off when otherwise we would be on ward duties, and also the rapid development of personal and clinical skills that comes from learning to make decisions on behalf of acute, undifferentiated patients.

If a shift or patient encounter has been particularly stressful, try to take a trusted senior or supervising colleague aside to debrief. 'Operational debrief' addresses the main questions that trouble us all, i.e. 'What was done well?' 'What was done less well? And 'What would I do next time?' and in the ED is added a particular mentoring and supportive element, because the senior doctor has either shared the experience and can reflect on it, or has been through similar experiences before.

If the term overall has been stressful, again approach a trusted colleague, but also seek out the term supervisor for a confidential discussion. Remember that your colleagues (including senior colleagues) also find work stressful at times. A common cause for the stress felt in ED is the high standards we all set for ourselves. These standards are important, but in ED we need to moderate our expectations by the awareness that we share care within a very complex system, and that no such system can be perfect. Try to get away on time and not take too much of the shift's difficulty home. Try to allocate time each week to things outside work that you enjoy and can look forward to. Try to get sufficient sleep. We do our best to provide encouragement and support, and to be flexible regarding compassionate leave, study leave (in liaison with the JMO office for rotating JMOs), or shuffling shifts if significant issues arise.

**References**


1. Sklar P et al. Unanticipated Death After Discharge Home From the Emergency Department. *Ann Emerg Med.* 2007; 49: 737-745.
2. Australasian College for Emergency Medicine. S18: Statement on Responsibility for Care in Emergency Departments. 2005
3. POW ED Clinical Documentation Policy, 2008
4. Australasian College for Emergency Medicine. G21: Guideline on clinical handover in the emergency department. 2010.


***Parking***

The campus parking is run by Metro parking and not by the hospital. Once you commence work at Prince of Wales you will need to visit the car park office on level B1 to put your name on the car park waiting list. The waiting list can be very long so in the meantime if you still wish to park in the Metro car park the cost for casual parking for a whole day is approx. $24.

They also have a 5 day staff pass that can be used for out of hour shifts, the rules for the out of hours pass are as follows:

- You must enter the car park after 4pm and leave before 8am the next day, otherwise casual rates will apply.
- Weekends – any time
- The cost is $17.30 and can be used over a three-month period.
- The pass needs to be purchased within 24 hours of entering the main car park.

During COVID there has been a relaxation of these rules, to the effect that if you are on an evening shift (not just after 4) you can take a routine ticket and have it validated at the enquiries counter in the Barker St forecourt.

Another parking option is Early bird parking at Ezipark next to Randwick Ritz cinema on St Pauls street. This is a $6 all day flat rate, you must be in between 5.30am and 11am and out between 2pm and 7pm

**Uniforms**

Scrubs are not mandatory and discretionary funding is not currently allocated to the ED to provide them. They may be used in accordance with the SESLHDPR/281. The approved colour for Junior Medical Staff is green/ emerald. https://www.seslhd.health.nsw.gov.au/Policies_Procedures_Guidelines/Clinical/Nursing_and_Midwifery/Documents/UniformsProvisionDressCodeandappearanceforClinicalandCorporate.pdf .

Resources for purchasing/ choosing scrubs include:

- https://www.infectious.com.au/
- http://www.healthshare.nsw.gov.au/__data/assets/pdf_file/0009/296244/Uniform-Catalogue.pdf

- Choosing a Scrub Style to Suit Your Body Shape (106.7 KB)

- Measurement Guide - Male Version 4 (1.1 MB)
- Measurement Guide - Female Version 3 (1.2 MB)