Emergency Department Survival Kit

2019 Orientation Manual
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ABOUT CABOOLTURE HOSPITAL

Caboolture Hospital is a 180 bed Community Hospital and is part of the Metro North Health and Hospital Service

The HHN is composed of:

- Caboolture Hospital
- Redcliffe Hospital
- Kilcoy Hospital
- The Prince Charles Hospital
- Royal Brisbane Hospital

The Caboolture Hospital has General Medical, General Surgical, Paediatric, Obs & Gynae, Mental Health, Coronary Care and Intensive Care Units. The Intensive Care Unit can manage High Dependency (non-ventilated) and ventilated Intensive Care patients.

Caboolture ED services a population of around 160 000. The catchment extends from the Glasshouse Mountains (North) to Deception Bay (South) and Kilcoy (West) to Bribie Island (East). The ED has 21 beds and sees 50 000 presentations per annum, 25% of which are under the age of 15.
Caboolture Executive and Unit Directors

- Executive Director: Dr Lance LeRay
- Director of Medical Services: Dr Lance LeRay
- A/Deputy Director of Medical Services: Dr Anand Choudhary
- General Medicine: Dr Salih Bazdar
- General Surgery: Dr Brian Kirkby
- Paediatrics: Dr John Waugh
- Obs & Gynae: Dr Mahilal Ratnapala
- Anaesthetics: Dr Ken Eastern
- Critical and Intensive Care: Dr Hamish Pollock
- A/Director Psychiatry: Dr Naeem Jhetam
Referral Pathways and Transfer to Another Hospital

For services not provided at Caboolture Hospital, below are the appropriate referral pathways for consultation, inter-hospital transfer and outpatient follow-up:

**Redcliffe Hospital:**
- Orthopaedics & Fracture Clinic Follow-up
- Urology

**Royal Brisbane & Women's Hospital:**
- Multi-trauma (referral via ED)
- Neuro Surgery
- Burns
- Vascular
- Maxillo-Facial
- Renal
- ENT
- Ophthalmology and Eye Casualty Outpatient Clinic
- Neonates

**Queensland Children’s Hospital:**
- ICU
- Surgery
- Burns
- Neuro/Neuro Surgery
- Medical
- ENT

**The Prince Charles Hospital:**
- Cardiology (including 24h Coronary Angiography)
- Cardio-Thoracic Surgery
- Fractured NOF
- Renal Calculi follow-up clinic (No Inpatient Urology)

**Princess Alexandra Hospital:**
- Spinal Cord Injury
- Hepato-Biliary/ Hepatic Transplant Unit
- SECU- Prisoners
Mission

Everyone Matters – Everyone Cares – EVERY TIME

Every patient in the ED will know that they are in safe professional hands, that they are cared for, listened to, and involved.

Values

Safety
Compassion
Professionalism

Patient and Family Centreed Care

Caboolture ED embraces the belief that the care we provide is respectful of, and responsive to, the preferences, needs and values of patients and their families.

Emergency Department – Leadership Team

- Director of Emergency Medicine: Dr Sean Keogh
- Deputy Director: Dr Sean Clark
- Nurse Unit Manager: Nerys Brackman
- Senior Admin Supervisor: Lisa Hayes
- Clinical Educator: Michelle Brown
- CNC: Janine O’Keefe
- Staff Specialists:
  - Dr Mosh Shittu
  - Dr Jennifer Shires
  - Dr Mark Scott
  - Dr Simon Bugden
  - Dr Suzanne Kenny
  - Dr Jonathan Thomson
  - Dr Alec Dearden
  - Dr Erica Gannon
  - Dr Emma Maguire
  - Dr Tri Slater
  - Dr Miron Kazi
  - Dr Andrew Dobinson
  - Dr Stephen King
  - Dr Danielle Spratt
  - Dr Maya Aoude
  - Dr Christine Waller
  - Dr Mary Basire
  - Dr Graham Zerk
  - Dr Douglas Feinbloom
  - Dr Tom Holland
  - Dr Lisa Kane (Paediatrician)
Accreditation

This department is accredited for 18 months of Advanced Training, including the logbook paediatric component, by the Australasian College for Emergency Medicine. Rotations for ICU, Anaesthetics, and Paediatric EM are available. Preference for rotations is given to trainees who are post-primary and have served in the ED the longest.

Advanced trainees can also complete the following accredited terms in Caboolture Hospital:

- Medicine
- Paediatrics (inpatient)
- Psychiatry
- O&G

Term Dates 2019 for SHO / JHO / Interns

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<tr>
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<th>Start</th>
<th>Finish</th>
<th>Number of Weeks</th>
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<td>1.</td>
<td>21/01/2018</td>
<td>14/04/2018</td>
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<td>2.</td>
<td>15/04/2018</td>
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<td>3.</td>
<td>24/06/2018</td>
<td>01/09/2018</td>
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<tr>
<td>4.</td>
<td>02/09/2018</td>
<td>10/11/2018</td>
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<td>5.</td>
<td>11/11/2018</td>
<td>19/01/2019</td>
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Term Dates 2019 for PHO/Registrars

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<tr>
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<th>Number of Weeks</th>
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<td>04/08/2018</td>
<td>26</td>
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<td>2.</td>
<td>05/08/2018</td>
<td>02/02/2019</td>
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**Triage**

- All patients have the right to be seen
- All patients presenting to the Emergency Department will be assessed by an experienced Registered Nurse and ranked in order of their clinical need to ensure that they are seen by a Doctor within appropriate time frames. Patients are allocated a number from 1-5 in accordance with the Australasian National Triage Scale.
- Patients suitable for Fast Track (treatment within 2h expected) are labelled “FT” and may be seen by a Nurse Practitioner, a Physio, or a doctor
- A Clinical Initiatives Nurse (CIN) will perform rapid assessment and initiation of care for suitable patients, using a chair at triage.

**Triage Categories**

The Australian triage scale is based on the urgency (not severity) of the presenting condition.

Cat 1: Receive treatment immediately: eg cardiac arrest, major trauma

Cat 2: Receive treatment within 10 min: eg chest pain, stroke

Cat 3: Receive treatment within 30 min: eg abdominal pain, limb fracture

Cat 4: Receive treatment within 60 min: eg minor injury, URTI

Cat 5: Receive treatment within 120 min: eg prescription, dressing

**At Caboolture patients should be seen in the following order:**

1. Cat 1
2. Cat 2
3. Patients prioritised on EDIS screen by consultant (red numbers in priority column)
4. Cat 3-5 in order of waiting time (ie see the longest waiting patient next, regardless of whether they are Cat 3, 4 or 5)

You may be directed by the consultant to see a specific patient at any time, regardless of the above instructions.
EXPECTATIONS – ED Professionalism Guide

The topics provided below are a guide to the expectations of health professionals during their ED term. They are also closely aligned to the criteria used to assess the Professional Responsibility component of your mid-term & end of term assessments.

Start time

It is expected that all staff are present in the fishbowl or handover room, bags away, ready to work by 0715 hours, 0730 hours, 1000 hours, 1300 hours & 2200 hours. If you are going to be late (even 5 minutes), please call the floor ED Consultant/Star REG (8458) to inform them, then also let them know in person once you have arrived. ED Consultants understand the occasional unforeseen circumstance. A pattern of lateness is unprofessional. A reputation for being 10mins early is golden. If you are late for 0730 hour handover, you will be asked to start seeing patients instead of attending teaching.

Patient food

CBH has a patient food is for patients only policy, this applies to everyone, all the time; no special rules for Doctors. If you miss cafeteria closing times, there are vending machines, delivery options & borrowing from mates. If you have food or drink in the work area, please be discrete and hygienic.

Clothing

People presenting to the ED are often anxious and distressed. For this reason it is important that we portray an image of professionalism. In ED we use colour coded scrubs, which are not only practical, but help the public to identify staff streams. Scrubs are inexpensive and voluntary; if you wish to buy 2-3 pairs the preferred site is http://www.rmfscrubs.com/home.php?cat=61. The style is your choice, but the colour is important: for interns, JHO’s and SHO’s, the colour is “C. Blue”. For registrars and PHO’s, the colour is “navy” blue.

If you prefer to wear regular clothing, please remember to be practical, as ED can be physically taxing (eg performing CPR), and the standard is “smart-casual”. For men this means collared shirts (no tie) and long pants, and women need to avoid clothing that is revealing or skin tight. All staff must wear closed-in shoes (no high heels please) for safety.
Sick leave
If you are sick we want you to stay home and recover. Please call the ED Consultant phone (5433 8458) as early as possible to allow time to find a replacement (don’t call switch or anyone else, 5433 8458 only). DO NOT use sick leave for “extra” days off (e.g. to get your car fixed, or extend your holiday). This just wears out your colleagues with extra work. We work as a team.

On-call
On-call is a part of being a doctor. From the start of the run please ensure both switchboard & our ED Administration Staff have all your contact details. When you are on-call you are required to stay within contact range and answer all calls. If your details change or you will temporary be out of range, please let switchboard know beforehand. We try to give you as many hours warning as possible.

Honesty
In Australian health culture speaking the truth is critical. Be honest on all occasions. When asked a question, it is acceptable to say “I don’t know”. Guessing an answer is the same as lying & never permissible. Life & death decisions are based on your information. Words have power, always be absolutely honest.

Contracts
Breaking a signed contract (for non-emergency reasons) is poor form. Your reliability & reputation are compromised if this happens. Unforeseen emergency reasons are understandable, extended holidays and new job opportunities are not. Patient care often suffers as it is very difficult to find replacements late in the recruitment year. If this occurs, it is not uncommon for this information to be passed on to future employees +/- previous referees. We are a team, we are loyal and committed to you, and we appreciate the same in return. If you anticipate problems with completing your contract, please discuss with the director as early as possible.

Patient talk
Humour is an essential & encouraged part of Emergency Medicine. There is however a line when humour can become unprofessional & a barrier to patient care. Our humour is overheard by patients & relatives; avoid humour that victimises marginalised groups eg. NH residents, IV drug users, chronic pain, frequent attenders, mental health patients, simple folk. Terms like NFC (normal for Caboolture) cross the line & are unacceptable – we are here to serve this community.

But why?
We want to develop a culture of excellent patient care with a high degree of professionalism seen in all staff.

- Failure on professionalism = failure of term, enters referee reports, ACEM trainee reports, MEO feedback, etc. May be part of feedback to original job application referees +/- medical board.
- It’s not heavy, it is collegial, simple & patient care focussed.

If you have any queries regarding clarifying or developing further professionalism skills, please do not hesitate to ask your friendly ED Consultant.
ROSTER RULES

Rostering

The ED operates a rolling roster over 12 weeks, so that you can predict your shifts well in advance. After trials of many styles of rostering, this is the model that was chosen by junior medical staff.

- Specific rostering requests may be considered in advance, please do not request changes once the roster is out.
- Shift swaps may be considered for special circumstances (see rules below). They can only be approved by the Director or Deputy Director.
- All rostering issues should be discussed with Dr Stephen King (Consultant) or the Director/Deputy Director if he is on leave. The Rostering Officer and/or Admin Staff – they are happy to collect your requests, but are unable to approve leave or solve your concerns, and any incidences of harassment will be referred to the Director.
- Emergencies (e.g. ill family member overseas) should be discussed with consultant staff as soon as possible, so that we can help you as much as we can.
- Couples (e.g. husband and wife) can NOT be routinely rostered together, please do not ask.

Leave

You are entitled to 6 weeks of recreation leave per year, see below for other types of leave. If you are working in the ED for less than a year, it is expected that you take a pro-rata proportion of your annual leave while you are with us. You are encouraged to have your leave, so to ensure that we maintain a quality service, we must plan leave well in advance.

- A leave planner is available to view in the Handover Room (on the noticeboard). No more than TWO registrars and TWO SHO’s can be on leave at any time (with rare exceptions approved by the Director). Choose a period that is available on the planner. Note – this only applies to doctors on 6-12 month contracts, all doctors doing a single term rotation have their leave supported by medical workforce.
- Leave applications must be at least three months in advance.
- Complete a leave application form and give it to the ED Rostering Officer. Dates of leave are in blocks of a week, from Monday to Sunday (except PDL which may be part of one week).
- Do NOT book flights or courses until your leave has been approved in writing.
- Do NOT request or expect “extra” days either side of your leave.
- Leave during the weeks before the biannual ACEM Primary exam is given to exam candidates as a priority, and apportioned as fairly as possible.

Details of other types of leave (eg PDL) are posted in the handover room.

Shift Swaps

Please do not seek changes in the roster unless absolutely necessary.

- You must swap within the same two week pay period
- You must swap with someone of equal rank (intern, JHO/SHO, PHO)
- The swap must not end up with anyone working unsafe hours – ie no more than 6 shifts in a row, no late-early’s, no less than 3 days off after nights
- The swap needs to account for any on-call responsibilities
- Request the swap on the designated form, with signatures from BOTH parties, submit to the ED Rostering Officer. Swaps will only be approved by the Director or Deputy Director, please do not ask other staff to sign them off.
- Swaps need to be requested at least 2 weeks in advance.
Overtime
Doctors should always aim to leave on time after their shift has finished (including completing patient notes). On occasion a doctor may be requested to work overtime. It is appropriate to spend the last 20-30 minutes of a shift completing work and NOT picking up a new patient, though it may be helpful to start treatment on a patient at the consultant’s direction.

- All authorised overtime will be paid, and must be claimed
- Drs should not continue to work after their shift has ended unless requested to do so by a consultant
- Overtime is approved on a form with the floor consultant’s signature, this is given to the ED Rostering Officer for processing
- Keep track of all claims to ensure that they have been paid correctly

On Call
The roster has daily on-call medical staff, to cover sick leave as needed. This is used at the floor consultant’s discretion, and is used as sparingly as possible. On-call shifts are paid, designated as “OC” on the roster, and call in may be for all or part of a shift. When on call you are expected to be contactable by phone for the 24h period. Most times you will have several hours of warning before starting work, not less than 1 hour.

Hospital Education
Junior medical staff are encouraged to attend formal teaching sessions in the Education Centre. If you wish to attend, please discuss with the floor consultant and make sure your patients are taken care of in your absence. Attendance is your responsibility.

- Intern education on Tuesdays at 1300 is mandatory
- Thursday Grand Rounds for all staff is encouraged
- Friday RMO teaching for all interns, JHO’s and SHO’s is encouraged
FATIGUE MANAGEMENT

- We care about you & our patients. Healthy teams look out for each other.

- All doctors are required to complete the online Managing Fatigue for Medical Officers learning module: https://qldhealth.lms.elmolms.com/index.php - create an account first. Once completed, please show certificate to ED Administration Staff for recording.

- **Meal breaks are mandatory!** All staff are required to have a 30min meal break. There is the ED tearoom, outside courtyard, chapel & outside seats to choose from. The hospital cafeteria, ED and hospital vending machines are available if you want to purchase food at work. You are responsible for the timing of your break, you don’t need to ask permission (just let the consultant know about your patients and where to find you).

  Don’t delay eating because patients are waiting, as long as all triage 1 & 2 patients are seen.

- **Night shifts** are a challenge for all staff. Driving home after night shift is a relatively high risk activity. In order to assist your safety, Caboolture Hospital has rooms available until 1100h, to sleep in following night shift. To access these:
  - Call OSO Supervisor (Ext 8615) between 0600h – 2200h to book a room.
  - Collect and sign for a key
  - Following night shift, travel to 16 College Court (see map) then … Zzzz
JUNIOR DOCTORS ROOM

Please make use of the Junior Doctors Room located in the mental health demountable (entrance is opposite the restricted car park entrance). It is an area which is specifically designed for the junior doctors to “escape” from the wards and meet with doctors from other units. There are kitchen facilities, TV, lounge, massage chair, computer and a rest area if fatigued. Also all mail (received through the hospital mail service) addressed to the RMO’s and Reg/PHOs are placed alphabetically in the pigeon holes located in this room.
COMMUNICATION

Patients

The ED is the start of the patient’s journey through the hospital – we set the tone for their hospital experience including the best possible outcome, and this relies heavily on good quality communication.

With every patient you see:

- **Listen** to their story – they have been mentally practicing it for ages! Let the patients say everything they want to without interruption for the first few minutes. Take the time to make sure you understand their emotional concerns. More than anything patients want to be heard.

- **Be Courteous** (including introducing yourself) – ask ED Consultants if you want some cultural advice on manners. Manners are beautiful … and very helpful.

- **Show Compassion** – Most patients are anxious, powerless, uncomfortable & tired. We are care professionals. Everyone dies, our job is to relieve suffering

- **Don’t Judge** – you don’t know the patients background –there’s always two sides to every story.

- **Offer analgesia**, toilet & food (if appropriate). And a **phone** to call relatives.

- **Explain** everything
  - Procedures
  - Investigations
  - Diagnosis and prognosis
  - Plan
  - Progress report
  - Plan at discharge (instructions and follow up)

Staff

You are expected to show courtesy and respect to all staff members, regardless of rank.

Referrals

With referrals, be clear about your expectation from the opening sentence: I am calling to a)ask you to admit this patient or b)ask for your advice. These are the only two options, please do not ask the inpatient team to take “a quick look”.

Use accurate and standardised language (SBAR). Be sure to convey the severity of the patients’ illness, socially important information & any time constraints.

Be respectful at all times. If the referral is not going as hoped or if an admission request is declined on the phone, please discuss with the ED Consultant.

Please notify the ED Consultant of any frankly rude or unacceptable behaviour from inpatient registrars. We all work as a team & bullying is not acceptable. Write the incident down, but NOT in the patient notes.
ED – Inpatient Interaction Principles

- At all times our primary goal is the best possible outcome for the patient
- We are expected to move the vast majority of our patients out of the ED within 4 hours (NEAT). Refer to inpatient teams by 2 hours wherever possible. Talk to the floor consultant about any barriers to the patient leaving the ED in a timely fashion.
- The ED senior medical officer cannot be obliged to discharge a patient whom they believe requires admission to the hospital.
- Inpatient unit doctors may discharge a patient directly from the ED if they do not agree that admission is required.
- The ED determines which unit a patient is admitted under and makes the appropriate referral. If, after reviewing the patient, an inpatient team believes the patient is better suited to another specialty, it is their responsibility to refer to that other specialty, rather than ED’s.
- Inpatient units have a right to know about patients being admitted to their unit, and to expect that required urgent investigation and management has been undertaken in the ED.
- The ED may admit patients directly to the ward with a management plan when the patient cannot be reviewed in the ED in a timely fashion.

Handover

Clinical handover occurs at all shift changes, and between consultants at 1600.

Handover is a time when the patient is highly vulnerable to medical error

Handover is a crucial procedure ensuring continuity of care, requiring observation of the following principles:

1. Every patient physically in the Dept must be under the care of an ED Dr with the name of the current Dr on EDIS at all times
2. The Dr giving handover is responsible for ensuring that all pertinent information including uncertainty about diagnosis, and concern about deterioration is conveyed
3. Ensure that all tasks are complete as far as possible before leaving (eg referral to inpatient team, prescription, letter to GP, detailed plan on EDIS, etc)
4. Handover should use the standard format of ISOBAR (or SBAR) to ensure clarity
5. The Dr receiving handover is responsible for satisfying themselves that they understand the situation, that the diagnosis and plan are correct
6. The outgoing Dr should ideally introduce the receiving Dr to the patient in person
7. The receiving Dr is responsible for personally reviewing the patient initially, and again at least once during the shift, depending on the nature of the illness
8. All patients must have a progress note on EDIS at least once per shift
10 PATHS TO PEACE AND HARMONY IN THE ED

The following tips will help provide good patient care, communication and teamwork

1. **Meditate on this truth:** “this patient is my responsibility”. It is your responsibility to make sure your patient gets the care they need, from you and others.

2. **Number one priority is resuscitation, before** notes and investigations, and sometimes before your history and examination is complete. Resuscitation includes analgesia, fluids and oxygen. Never leave patients in pain. Check frequently, and treat until the patient is comfortable. Tell the consultant immediately if your patient has abnormal vital signs (eg hypotension, low GCS). Learn how to use the Morphine Protocol.

3. **If you don’t know what to do, ASK.** If the diagnosis or plan is not clear to you don’t wait, get help. If you don’t understand an instruction from a senior, ask for clarification. If you don’t know how to do something, ask.

4. **Dispose of all sharps, immediately**, in the correct containers. If another staff member injures themselves on your sharp, you may be held responsible for the consequences. **ALWAYS** wear gloves when handling sharps (especially iv cannula).

5. **Clean up your own mess**, including blood spills, iv, suturing and plastering equipment (and food!)

6. **Label your blood specimens at the bedside.** Check it’s correct

7. **Talk to the nurses** If you chart medication, tell the nurse as well as writing it down. When you have a plan, or a change in plan, tell the nurses.

8. **Make your notes complete.** Others depend on these notes for re-presentations, recalls, follow-up, and medico-legal reports, after you have finished your ED term. Be sure to include social history, diagnosis, progress notes, details of consultations/referrals, and follow up plans.

9. **Make admission decisions early** Please make sure your patients have a decision to admit, go to SSU, or go home by the time they have been in ED for 2h. Put time and referral to inpatient team in EDIS.

10. **Help out answering the telephones around the work area** If you are next to the ringing phone, and there is no communications clerk available, you answer it.
Medical Records

Notes are typed into EDIS “Clinical Notes”. When constructing your notes, consider the following:

1. They represent your assessment and your decision making process. The next person to read your notes should clearly understand what was going through your mind, and how you reached your conclusions.

2. Relevant details help us manage things like police reports, complaints, adverse incidents, etc. “If it isn’t written down, it didn’t happen.”

Essential elements for all patients:

- Presenting Complaint – can’t have too much detail here!
- Relevant past history
- Medications and allergies
- Social history* (including employment, or ADL’s for elderly)
- Examination (minimal abbreviations, separate out systems)
- Diagnosis (or differential) and active problem list
- Plan
- Discussions with consultants other departments
- Progress notes while in ED. (At handover, at least once a shift, and after every patient contact)
- Results of investigations; including MSU & ECGs
- Discharge plan

*The items underlined are often missing in patient notes.

These are the same elements assessed in the documentation component of your mid & end of term assessments; all components need to be present.

Medications must be charted correctly on either an adult or paediatric drug chart. Nurses are not permitted to give drugs on verbal orders (except in an active resuscitation).

Examination

All patients must have a documented examination relevant to their presenting problem. This includes a Mental State examination for Psychiatric patients (and a suicide risk assessment), and a vaginal/speculum examination for O&G patients. Please be specific about your findings – “grossly normal” is not an acceptable entry.
WORKLOAD

INTERN/JHO/SHO

- Do not have admission/discharge rights. They must discuss each patient with the Duty Consultant/Star Registrar prior to contacting the In-patient Registrar or discharging home.
- Must discuss the patient with the Duty Consultant/Star Registrar within 30 minutes of reviewing the patient and be prepared to offer a diagnosis and treatment plan within one hour.
- If you suspect that the patient is potentially seriously unwell – Consult immediately.
- Patients generally should not spend more than 4h in the department. If there are delays, or you are unsure of how to proceed – ask for help.
- If there are problems with staff in other departments – ask for help.
- If a patient represents unexpectedly, with the same or similar conditions, within a short time (e.g. days) – notify the Duty Consultant. Re-presentation may indicate an unresolved problem.

PHO/REGISTRAR

- During night shift, when there is no Duty Consultant on the floor, the Star Registrar is expected to supervise the ED. Your role is to ensure the smooth functioning of the department. This takes priority over seeing patients yourself.
- At all other times, registrars are required to assist in supervising junior staff, especially when consultants are unavailable. RMOs must present their patients to ED PHO/Regs at these times. Teaching is part of the PHO/Reg job description. Academic acknowledgement of this can be obtained by all ED Registrars via applying for the academic title of Associate Clinical Lecturer from the University of Queensland. To obtain an application form, see the ED AO at the start of your term & the start of each academic year.
- PHO/Registrars are encouraged to actively chase sick patients, resuscitations and critical care patient transfers.

Ward Cover

Junior doctors currently do not provide after-hours cover for the wards while rotating through ED.
EXPECTATIONS: EDUCATION AND LEARNING OBJECTIVES

The ED is a great place to grow in your clinical skills and confidence. You have the “first crack” at diagnosing and managing undifferentiated patients, but in a very supervised environment, so you should never feel out of your depth. Most doctors who have never worked in an ED before are very anxious about it, until they discover that Caboolture has a very friendly and supportive culture, allowing maximum learning with minimum stress. So…

We expect you to learn a lot and enjoy your ED term!

General Principles department education:

The education program at Caboolture ED has a clear focus on communication, patient focus, and team work. All medical staff are expected to attend and contribute to departmental education sessions.

If you are allocated to present and are unable to do so in the allocated day, it is your responsibility to arrange someone to present in your place and to notify the coordinator of the session in advance of the change.

At the start of each term junior medical staff will receive a copy of the orientation manual and a copy of the departmental education roster. Each doctor will also receive a face to face orientation either individually of during the first education session each term.

You are required to sign off that you have read and understand the orientation manual before starting work on the floor.

Each junior medical staff member will be allocated a supervisor. You will meet your supervisor for a mid and end of term assessment. Please make an appointment at the start of term:

- Introduce yourself to your supervisor at the start of term
- Be aware of your learning objectives for the term
- Be aware of the education roster and any contribution you are rostered to make
- Be aware of the minimum standards of performance for your level

Intern and Junior Doctor Learning objectives:

These are set out by the Australian Curriculum framework for Junior Doctors; [www.cpmec.org.au/curriculum](http://www.cpmec.org.au/curriculum) and in the Caboolture Hospital: POLICY ON SUPERVISION OF CLINICAL EXPERIENCE FOR JUNIOR DOCTORS. Individual learning objectives and expectations will be set in conjunction with your supervisor. The Core expectations are set out below:

ACEM trainee Expectations:

In addition ACEM trainees are required to familiarize themselves with the requirements for training in Emergency Medicine as set out in the ACEM training and examination handbook. Talk to the DEMT as soon as possible, to discuss your term.

AMC Expectations

The department supports and encourages doctors working towards AMC examination success.
ASSESSMENT AND FEEDBACK

ASSESSMENT PROCESS

An intern will be assessed in all five terms in the first postgraduate year (PGY 1). It is essential that the performance in all these terms is satisfactory, to enable the intern to progress to general registration as a PGY2.

All interns will have a formal end of term assessment completed by their supervisors.

All pre-vocational junior doctors at Caboolture Hospital are assessed in a similar manner during their terms in all units.

All assessments are completed by the consultant group as a consensus in meetings arranged prior to feedback. Information is gathered from consultant interaction with you, as well as feedback from patients, nurses, and your colleagues.

FEEDBACK

During the term you will be provided with formal and informal feedback on your performance (clinical, professionalism, communication) from your supervisor.

Mid Term

The mid-term (appraisal) interview is formative (ie it does not contribute to your final assessment.

This mid-term interview provides an opportunity for a discussion between the supervisor and the junior doctor, and an appraisal of your current performance.

He or she provides you with individual and constructive feedback on your progress, and any necessary guidance in order to improve your performance.

This is also an excellent opportunity to discuss progress made towards the achievement of your learning objectives which will have been discussed with you at orientation.

End of Term

The End of Term Assessment is summative (i.e. it will indicate whether your performance has been satisfactory or unsatisfactory).

This interview should be scheduled as a formal interview, at which time both you and your supervisor will discuss the assessment form and sign off on it.

Please be proactive in ensuring you receive both mid-term and end-of-term feedback.

For interns and those junior doctors without general registration, the Australian Health Practitioner Registration Agency will be informed of the result of your assessment.

UNSATISFACTORY PERFORMANCE

Unsatisfactory performance is almost always identified by the mid-term assessment, and is uncommon. If you receive an unsatisfactory assessment at mid-term (or end of term), your supervisor will contact the Medical Education Unit.

An Improving Performance Action Plan (IPAP) will be developed by your supervisor with the assistance of the Medical Education Unit (DCTs and MEOs). Completion of the terms of the IPAP is your responsibility. NB: failure to complete the IPAP is an automatic failure of the term.

The personnel of the MEU will be able to assist you in complying with the requirements of the IPAP; they are also able to support you and provide you with advice and assistance in many ways.

They can also arrange access to the Employee Assistance Service (EAS) – professional psychological support - if appropriate.

NB: the great majority of those on an IPAP pass the term after completing it!
Orientation Checklist

- Sign off that you have read and understood the ED Survival Manual

- (you are not permitted to start work until you have done so)

- Get Novell, Groupwise, Auslab, EDIS log-ons

- Obtain the latest roster

- Check when you are rostered to give a teaching session

- Apply for any leave you may want (3 months in advance)

- Make sure the ED AO and Switchboard have your phone numbers and your home email address

- Order your scrubs if appropriate

- Be aware of your on-call requirements

- Get training on EDIS

- Make sure you complete your mandatory training requirements as soon as possible

- Familiarise yourself with the Resuscitation room and its equipment lay-out
DISPOSITION

Admissions

- NEAT: National Emergency Access Target. By the end of 2015, it is expected that 90% of all ED patients will leave the ED within 4 hours of arrival. This means that we need to make a decision on disposition within 2 hours of arrival for most patients. The “Logistics” nurse monitors all patient movement and flow in ED.

- Admission decisions: The ED has the right to determine whether or not a patient is admitted and under which team (except MH and HDU). Disputes must be escalated to the senior doctor on duty. Interns, JHO’s and SHO’s must discuss their patient with a senior before admission or discharge.

- Check that the patient is not DVA and does not have private insurance

- Notify the nurse Team Leader. Complete the admissions form

- If there is a delay of >1h in the registrar reviewing the patient, notify the consultant.

- ICU. ICU referrals must be made Consultant-to-Consultant, including overnight. The ICU Consultant will generally then contact the ICU Registrar to perform the admission.

- CCU. CCU patients must be reviewed in the ED by the Medical Registrar prior to admission. Direct admissions to CCU are not permitted.

- MHU. All patients threatening suicide or on an EEA must be seen by Acute Care Team. Patients are usually referred at triage. Intoxicated patients will not be assessed until sufficiently awake (8/10 on MSQ, see policy). All admitted patients require a medical clearance form to be completed.

- Direct admission: Many patients who are being admitted to hospital can go directly to a ward bed without waiting for inpatient registrar review in ED. There is a policy with rules, and a form (checklist) to complete.

- Discuss possible Non-Accidental Injury cases (child abuse) with the consultant and the paediatric team.

Transfer to a public facility

- If a receiving unit registrar will not accept the transfer, this must be discussed with the senior ED doctor.

- Transfers are often a complex negotiation process regarding best treatment, timing, bed availability, interim care, documentation, etc. make sure all the “pieces” are in place:
  - Discuss with your consultant and the accepting registrar,
  - Complete an Inter-Hospital Transfer (IHT) Form is completed and printed.
  - Notify the Logistics Nurse who will call the bed manager at the receiving hospital to ensure bed availability, and book an ambulance.
  - Ensure all notes are up to date & photocopied with X-rays & a referral letter (the Comms clerk will do this)
  - Tell patient and relatives of plan
  - Notify ED of receiving hospital, and receiving unit when patient departs
  - Ensure temporary treatment is in place, including a back-slab, antibiotics, analgesia, IV fluid etc.

Transfer to a private facility

- All patients with private insurance or DVA cover should be offered the opportunity to transfer. It is their choice.

- DVA patients and patients with private insurance can, in general, go to any private hospital under any specialist they choose in SE Queensland.

- Patients should be given a brochure explaining the process and possible expenses

- Finding an accepting hospital/specialist can be time consuming – you need to balance this with the need to see other patients (eg try 2-3 hospitals, then perhaps elect for public admission).
• Ensure that the Referral Letter includes the accepting consultant’s name, your name and provider number.

SSU

• Intended for short term rapid turnover ED patients (<24h)
• Opt for the SSU early (2 hours) if you anticipate the patient will be going home, but need a bit more observation or treatment
• Ensure all medications (including patients regular meds) are charted along with IV fluids prior to transfer to SSU; you remain responsible for your patient
• Admission requires permission from the senior doctor.

HITH (Hospital in the Home)

Patients requiring IV antibiotics can be sent home with a cannula in situ and followed up at home by the HITH service. Discuss with the Medical Registrar. The Patient Flow Facilitator can organise other home services, wound clinic, post-acute care, etc. This is generally suitable for uncomplicated patients, who live nearby, with UTI, pneumonia, and or cellulitis.

GEDI (Geriatric Emergency Department Interventions)

The GEDI nurse (Monday to Friday) are available for referral and will actively seek out elderly patients (>75yo) and Residential Aged-Care Facility (RACF) residents in the Emergency Department. They are able to provide assistance on a range of issues related to the care of the Elderly, with a particular focus on preventing hospital admission where possible. They are able provide assessments and assist in organising home care arrangements for independent patients, and liaise with RACF staff and GPs to facilitate ED-initiated treatment plans in the Nursing Home.

Social Work – Extension 8102

Social workers cover the Emergency Department Monday to Thursday 0800 – 1600 and Friday 0800 – 2030. Outside these hours referrals can be made via the out of hours referral folder (at triage) or a message left on extension 8102. These referrals will be followed up the following day. Referrals to Social Work are appropriate for a wide range of situations including (but not limited to): grief and loss, intervention re family violence, sexual assault and family support for critically unwell patients.

Outpatients

ED is not permitted to refer patients to routine OPD appointments. The procedure is to refer back to the GP and request that they arrange/coordinate OPD. Exceptions to this rule include referrals to

• urgent appointments, which are simply discussed with the inpatient registrar
• renal calculi – TPCH clinic
• Fracture Clinic and Trial of Void (TOV) at Redcliffe
• Chest Pain Assessment Service (CPAS)
• ENT Lady Cilento Children’s Hospital (LCCH) referrals for difficult to remove foreign bodies. Contact on-call ENT registrar to arrange follow up in clinic the next day. Alternatively, once per fortnight there is an ENT outpatient clinic at Caboolture Private Hospital.
DISCHARGE HOME

 Patients being discharged home from the ED are an “at-risk” group from the point of view that they are no longer subject to our observation and can come to harm through deterioration in their medical condition, missed diagnoses, lack of follow up, or inadequate self-care.

Discharge Timing

There is an increased risk to the patient who is discharged during the night (10pm to 7am) compared to other times (reduced monitoring and access to supports, increased risk of deterioration). Extra caution should be exercised when considering discharge (at night) for the following people:

- Small children
- Elderly
- Intoxicated, or drug overdose

Minimum Safe Discharge Criteria

1. **Resolution of disease/symptoms** to a level that can be managed at home (eg asthma, pain). Unlikely to deteriorate or recur.

2. **Stable chronic disease**. If presenting with exacerbation of a chronic disease (eg COPD, CHF), be very cautious that the condition is stable and unlikely to deteriorate further. When in doubt admit.

3. Able to **mobilise safely** to toilet and shower. Able to **drink fluids** without vomiting. Able to **pass urine** (if relevant).

4. **Resolution of confusion, sedation, or intoxication** to a level of safe self-care, or safe care by a responsible adult in the same residence

5. Appropriate **supports** in place (eg carer, responsible adult, blue nurse) as required. Appropriate **transport** home and access to telephone for urgent return to ED if required (when relevant)

6. **Safe home environment** (eg heating, stairs), and responsible adult at home to receive and care for them where needed

Expected Standard of Care at Discharge

**NB:** Not all items will apply to every patient

Document what information has been communicated to the patient

1. **Education** for the patient (and family):
   a. test results
   b. diagnosis
   c. prognosis
   d. instructions at home
   e. instructions for when to consider urgent return to ED.

2. **Written information** on their condition (use preformatted info sheets on ED website where appropriate) for the majority of patients

3. **Follow up** plan (specifically who and when)

4. **Medication**. Return own meds, new prescriptions

5. **Liaison** with people who are taking over immediate care, such as family, nursing home, or GP.

6. **Letter** to GP. Include test results (copies if relevant), diagnosis, plan, and recommendations

7. **Certificates**. Worker's Comp, Centrelink, plain medical certificate.
MET CALL

Medical Emergency Team

Dial 666 or Press Red Medical Emergency Buttons

Nursing and Medical staff in the wards can trigger a MET call when patients are found to be deteriorating (based on the ADDS scoring system used in the wards, see next page). The intention is to treat patients before a cardiac arrest occurs. The following staff carry a MET pager and are expected to attend a MET anywhere on hospital grounds, day or night.

- Medical Registrar
- Emergency Department Resident – day/evening shift
- Emergency Department Registrar – night shift
- After Hours Nurse Unit Manager
- PSA

If you are a PHO in the Emergency Department, you will be expected to wear the MET Pager for emergencies and be part of the resuscitation team. Please hand over the pager at the end of your shift.

The hospital agreed MET criteria are listed on the next page.
What’s the score?
Know your response.

By recognising clinical deterioration early and through prompt and effective management, we can reduce unnecessary adverse events and improve patient outcomes.

The use of ADDS assists in:
- Recognising patients whose condition is deteriorating
- Responding to their needs in an appropriate and timely way
- Recognition and response systems are applicable to all patients and ensure:
  - Effective assessment
  - Effective interpretation
  - Effective communication
  - Effective action and timely response

Contact:
Email: RMDP@health.qld.gov.au  Phone: 3646 6646

Patient Safety and Quality Improvement Service
Infection Control & Work Place Health And Safety

(a) Standard Precautions

- Standard precautions are the basic level of infection control for the treatment and care of all patients, irrespective of their perceived infectious status and include:
  - Wearing of gloves when handling items contaminated with blood or body substances; and **ALWAYS** when handling sharps
  - Containment of blood and body fluids by wiping spills immediately, to prevent tracking of floor spills (See Infection Control Manual);
  - Minimal handling of contaminated items, thereby reducing the risk of exposure; careful handling and disposal, into designated receptacles, of needles and other sharps to minimise the risk of accidental injury.

(b) Additional Precautions

Additional precautions are used for patients known or suspected to be infected or colonised with epidemiologically important or highly transmittable pathogens that cause infection by:

- Airborne transmission (e.g. TB, measles virus, varicella virus);
- Droplet transmission (e.g. mumps, rubella, pertussis, influenza);
- Direct or indirect contact with dry skin (e.g. colonisation with MRSA or with contaminated surfaces).

ED Infection Control and Waste Management

Some equipment is disposable (eg suture kit), some is placed in the pan room for washing and sterilisation by CSSD (eg ENT instruments). Do NOT throw out equipment that is not disposable (eg light source for PV specula)

Sharps are placed into sharps containers in each area. ¾ full containers are replaced by the OSO, ph 8233. Do NOT put swabs, dressings, etc in here.

YELLOW garbage bags are used for contaminated waste.

Emergency Procedures

Please familiarise yourself with the evacuation area for ED and the alarm buttons:

- Staff assist
- Duress Alarms
- Code blue alarms (MET activation)
- Disaster phone (external)
- WHIP phone (fire)
Paperwork & Enquiries

Patient Enquiries

Be aware of patient confidentiality. You can advise callers that a particular person is here, but provide no other information. Alternatively the patient can talk to the caller directly using the portable phone, or the patient may give a message for the staff member to pass on.

Phone Advice

When people ring asking for Medical advice, only the following may be given:

- First aid advice.
- Advise the caller to present to Emergency Department or their GP if they are concerned.
- No other advice is to be given. Waiting times are not given over the telephone, patients can be advised that the triage system ensures that everyone is assessed and seen according to their presentations.

Media Inquiries

No information can be given over the phone or in person to a member of the media. Refer calls to the Consultant on duty, or the Director.

Police Inquiries

- No information can be given over the phone. Police must present in person and speak with the treating Medical Officer directly, or they can direct their inquiry to the Medical Superintendent.
- Police reserve the right to interview a patient following a MVA or an assault, if the patient’s condition allows this. However if the patient disagrees, police will follow up later.
- In October 2002 Police were given the power to direct health care workers (Doctors, Registered Nurses, persons trained in taking blood samples) to take blood samples for alcohol level, from patients who may be uncooperative unconscious or otherwise not able to give informed consent. Police will provide the blood sampling kit. We will not take forensic samples from people brought in by police who are not sick or injured (ie do not require medical attention).

Abusive, Threatening People/Patients

The Emergency Department has been identified as a high risk area. The hospital has a zero tolerance policy for all forms of abuse.

Call security early in such situations. If you feel there is a threat to anyone’s safety activate a code black by dialling 666, or use a duress alarm. DOCUMENT the incident on an incident report form. Police can be called at any time.

You are NOT obliged to treat abusive patients. Discuss with a consultant.

Workers Compensation Certificates

Any patient whose illness/injury occurred while at work or while attending a work function, or while travelling to or from work should be given a certificate. Forms available in work area. Top three copies to patient, last copy in patient’s chart.

Medical Certificates

Any patient likely to be off work who does not qualify for Worker’s Compensation should be offered a plain medical certificate. The diagnosis is not put on the form unless the patient requests this. The form can also be used for those attending ED with the patient. Patients receiving a benefit may also request a Centrelink certificate.
Reports
Do not supply anyone with police or other reports (eg insurance reports). These are all handled by Freedom of information office on the ground floor in medical records.

Prescriptions
Hospital prescription pads are in triplicate (top two copies to the patient, last one in the chart). They can be used at the hospital pharmacy and also at local pharmacies. Generally we avoid supplying routine medications for patients. Supplies of all medicines should be short term only. Prescriptions for opiates are only given in rare circumstances.

Equipment
Crutches, knee immobilisers, etc are on loan to patients. There is no hire fee but patients are advised to return items when they no longer require them.

Needle Stick / Body Fluid Splash
If a needle stick injury occurs, obtain a Needle Stick injury pack from triage area, and notify the consultant who will delegate a doctor to take your blood and help you complete the paperwork process.

Death in the Emergency Department
When a patient dies in the ED, locate the “death in ED” pack in the filing cabinet in the work area. Complete all the instructions contained in the pack and return the empty folder to clerical staff. Options for certification are:
Write a death certificate (top copies go with the body, last copy in the chart)
Speak to the coroner if you would like to write a death certificate but are unsure
Refer to the Coroner via Police

Dental
There is no emergency after hour’s dental care available at Caboolture ED. Patients wishing after hours dental care should refer to the yellow pages. The Emergency Department can provide analgesia and antibiotics if required.

Interpreters Service
Reliance on friends or family members to provide interpretation for non-English speaking clients has been determined as a risky activity. If you require an interpreter discuss this with the consultant. Contact is through switch.
PATHOLOGY

- The laboratory is open 24 hours a day.
- Microbiology and uncommon blood tests are performed in Brisbane, eg. CSF samples need to be sent via taxi and results phoned – tell lab staff you are doing an LP.
- Samples can be sent to the lab via the Lamson Tube.
- Turnaround time is roughly 1.5h for routine bloods
- Try to order only tests that will make a difference to the patient’s management today. For example, wound swabs rarely alter management at all and stool cultures should be ordered and followed up by GP’s. Routinely used blood tests are listed on the pathology palette on EDIS.
- All blood tubes must be labelled at the bedside, including blood gases
- Request forms should be computer generated by EDIS or using ED-specific blue ordering forms.
- You should have an ‘Auslab’ access code and a code to use the ABG machine (but you need training first).

When a patient under your care is discharged for the emergency department, *it is your responsibility* as the treating clinician to:

1. **review all results** prior to the patient leaving the department
2. **document in the patient record** that you have reviewed results & what action you have taken to treat and follow-up any abnormal results
3. **arrange follow-up of** all outstanding/pending results

Formal radiology reports and microbiology (pathology) reports are returned to the emergency department for review (box near secretary’s desk). Each day, the SHO allocated to SSU in the morning, is expected to go over these Radiology and Pathology reports (at about 3pm) and look for any abnormalities, such as missed fractures, or positive blood/urine culture results. The registrar must follow up any discrepancies by calling the patient, and documenting in EDIS notes the intervention taken, and the new plan. Sometimes, patients may need to be asked to return to the ED for further x-rays or treatment. Other times, they may be able to follow up with their GP. Ask the Consultant if you have any questions.
Clinical Investigations ordered in the Caboolture Emergency Department

Common examples of abnormal test results in patients going home:

**Result:** Abnormal LFTs in asymptomatic patient eg. AST 55 [<35 is normal]

**Action:** inform patient, letter to GP asking to review patient and repeat LFT’s as required. Document the result and plan in notes.

**Result:** Asymptomatic raised blood glucose eg. 10.9 (normal <7.8mmol/L) not known to be diabetic

**Action:** inform patient, letter to GP asking to repeat fasting glucose, document result & plan in notes.

**Result:** low Potassium (K = 3.1 mmol/l)

**Action:** inform patient, letter to GP asking to follow-up, prescribe oral replacement, document result & plan in notes.

**Result:** You have ordered TFT’s (after discussion with a senior) but they are not back by the time the patient leaves the department

**Action:** Inform patient that there are outstanding results that need follow-up, letter to GP asking to follow-up; document plan in notes.
**MEDICAL IMAGING**

- Medical imaging is provided by a private organisation (IMED), and is open 24h for plain films and CT.
- Ultrasound is available in daytime 7 days a week and on-call thereafter (strict rules for use).
- **CT, Ultrasound and MRI require consultant approval at all times.** MRI requires a FACEM provider number on the referral. MRI is available outside of office hours, but only for medical emergencies. Contact a consultant first.
- Request forms must be filled in, including appropriate clinical information ("CXR – SOB" is insufficient), and all allergy questions if the patient is having contrast.
- **The patient (or delegate) must sign the yellow box to confirm the correct name** (this process was implemented as a result of recurring identification errors and it has been very successful).
  - When you sign a medical imaging request form, **check** that the correct patient sticker has been applied
  - **Tell the patient in person** what procedure you are ordering and why
  - Ask the patient (or parent/carer) to sign the consent box, and explain that **they are checking that the name is correct on the sticker**
  - If the patient is unable to sign and no carer present, ask a staff member **who knows the patient** to sign it. Do not sign it yourself.
- Ultrasounds deferred to the next morning: place the form in the Perspex box in the X-ray area, IMED will contact then patient with an appointment. The patient may need to be reviewed in the ED afterwards.
- Imaging deferred to morning for patients still in the department: forms for booking are handled by the day staff member responsible for the patient.
- Get in the habit of reading your own films. If you are unsure, ask a consultant for help. A radiologist is on site until 5pm weekdays, and some weekends, to give opinions as well.
- After hours, an on-call radiologist will provide a written report by fax.
- Questions about policy should be directed to the radiographer, eg
  - Use of contrast in renal impairment
  - Use of oral contrast
  - Use of "whole of limb" x-rays or multiple parts (eg foot and ankle)
  - Comparison views
  - CT, contrast, splinting in children
Night Shift – When Should I Call the Consultant?

On the night shift the Registrar in charge ‘Star Reg’ will be the primary decision maker. Calls to the consultant are appropriate when there is uncertainty about patient care that cannot wait until morning. Such calls should begin with a statement about whether you want the consultant to come in, or you just want advice.

“I need you to come in” or
“I don’t need you to come in, but I need to discuss this with you”

You are always welcome to discuss cases with the consultant on call as required, but the following situations are mandatory consultations:

1. **Critical Care Patients** eg: all ICU referrals, Major Trauma, patients requiring intubation, Unexpected Death in Department

2. **Deteriorating Patients** – a patient who deteriorates in the ED (eg: hypotension, falling GCS) will be notified to the star registrar. If there is no satisfactory resolution of the problem (eg: improves again or the ARP in place) within 1 hour, either you or the team leader must call the consultant

3. **Procedural Sedation** – if unable to wait until morning

4. **Acute restraint** and sedation (‘take down’)

5. **Inter-hospital transfers** escorted by a doctor

6. **Thrombolysis** – involve the consultant in the decision on whether to not to give this treatment.

7. **Disaster** – any code brown, code yellow, evacuation or multi-casualty incidents

8. **Department unsafe** – eg: workload, acuity, skill-mix etc

9. **Major error** in patient management

10. Major **adverse interaction** between staff members

ANY member of staff (medical or nursing) who has serious concerns regarding patient care or departmental safety can escalate their concerns to the on-call ED consultant.
Danger Will Robinson!
The following are common examples of situations prone to judgement error, when patients can have unexpectedly bad outcomes. Beware!

1. Handover.
Vital information is often lost at this point and compounded by multiple shift changes. To minimise this:

(a) Use standard SBAR communication
(b) Write it down where possible
(c) In addition to data, hand over your thought process, your uncertainty, and if you are worried. Always mention abnormal obs.
(d) Go and talk to the patient together. Handover at the bedside as much as possible.
(e) When receiving handover, make sure the diagnosis and plan are clear in your own mind. Check the patient (and notes) yourself.
(f) Agree on what tasks remain and who will do them

2. High risk patients
(a) Frequent Flyers – familiarity breeds contempt. There is a risk of both a bad attitude towards the patient, and dismissal of genuine symptoms or new problems
(b) Elderly – higher incidence of serious illness (eg ACS, sepsis, surgical abdomen) often with minimal signs, symptoms or blood test abnormalities. Beware diagnoses such as constipation, mechanical fall.
(c) Mental Health – dramatic and demanding behaviour can sometimes distract from physical illness or injury
(d) Intravenous drug users (IVDU). As for mental health. These people are at higher risk of serious illness. Don’t be hasty in labelling people as drug seeking.
(e) Second presentation for the same problem. Look more carefully rather than less, consider more investigations, discuss with the consultant.

3. High Risk Presentations
Certain presenting symptoms should generate “knee jerk” thoughts of rare but serious illness hiding in amongst common benign conditions. For example:

(a) Back Pain – could it be an epidural abscess or cancer?
(b) Renal colic in elderly – could it be an aortic aneurysm?
(c) PV bleeding in first trimester – could it be an ectopic pregnancy?

4. Discharge home
There is a whole policy dedicated to this, see above.

5. High risk times
Your judgement may be suboptimal

(a) End of your shift
(b) If you are tired, hungry, or upset
(c) Last couple of hours of night shift
(d) During a “surge” of patient load when many rapid decisions have to be made
Appendix 1

Metro North Hospital and Health Service

Procedure
Caboolture Hospital, Emergency Department
Effective from: April 2016
Review due: April 2017

Violent or Aggressive Patients in the Emergency Department

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Purpose and Intent
To provide guidance on the safe management of aggressive patients in the Emergency Department.
Scope and Target Audience
The target audience for this procedures applies to all permanent, temporary and casual staff working with the Emergency Department, Security and Operational Support Officers who respond to code 'BLACK' events at Caboolture Hospital.

Principles
- Queensland Health has a “zero tolerance” attitude to aggression in the workplace, and aggression (verbal, physical, or sexual) from patients is unacceptable in this Department.
- The safety of staff and other patients is paramount when considering management of an aggressive patient. In some instances this may require delay in treatment (where presenting problem is non-lifethreatening) until a patient is no longer a threat to staff safety. Patients will still be treated with dignity and professionalism at all times, regardless.
- Verbally abusive patients (or family) will be warned twice and then escorted from the ED by security staff, if it is clinically safe to do so. Security should be notified early when ED staff are concerned.
- All staff are to attend training in management of aggression, and will be supported with leave to do so. All staff will familiarise themselves with use of duress alarms at orientation.
- Staff will not attempt to manage a patient alone where they feel unsafe or threatened.
- Extremely violent patients, including those with weapons, should be managed by the Police in the first instance, and not confronted by staff.

Procedure / process
Potentially Violent Patient
1. Involve senior nursing and medical staff immediately
2. Call security to the department as backup (Use ‘Code Black’ if the threat is immediate)
3. Where possible isolate patient from other patients in quiet area
4. Consider acute medical causes that may respond to immediate therapy (eg hypoglycaemia, hypoxia, hypotension)
5. Use verbal de-escalation techniques (as per ABM training):
   a. Listen to patient’s concerns, address aggravating factors where possible
   b. Empathise, explain, do not patronise or threaten
   c. Negotiate reasonable behaviour (food, drink, exercise)
6. Consider Mental Health Act (MHA) Request and Recommendation forms (R&R) early for Mental Health patients
7. Consider offering oral sedation: Diazepam 10mg, and/or Olanzepine 10mg
8. Patients who do not meet the criteria for restraint (below), should be permitted to leave the Department, and Police called if necessary.
9. When above fails or is inappropriate, consider restraint and sedation
Chemical Restraint
Rapid, safe, restraint and sedation of patients deemed to be a serious and immediate risk to themselves or others. Staff safety, and that of the patient; are of paramount importance. The patient’s dignity, confidentiality and rights will be respected.

Patient Inclusion Criteria
There should be evidence that the patient meets all of the following:
- Requires hospitalisation
- Non-compliant with treatment or admission
- Lacks capacity (ability to give informed consent)
- Aggressive and at risk of becoming violent
- Attempts at verbal de-escalation unsuccessful or inappropriate

Practice Point 1:
Involuntary sedation is an assault if the above criteria are not met (Criminal Code Act 1899). Sedation is a form of therapy to reduce psychological suffering and ensure safety, it must not be used for convenience or punishment.

Personnel
1. Notify:
   a. The most senior doctor and Nursing Team Leader (TL) on the floor
   b. ED consultant for: children, pregnant women, complex situations, inadequate skill-mix overnight, and those who also require mechanical restraint in addition to sedation.
   c. Psychiatry registrar when appropriate
2. Ensure adequate staffing for the procedure, including a doctor with airway management skills
3. If Police in attendance, ask them to stay and assist until patient is sedated
4. Ensure patient is contained and occupied while preparations are made
5. Ask TL to call Code Black

Environment
1. Identify appropriate space to perform sedation, ideally Resuscitation, alternatively a monitored cubicle. Avoid using Fast Track or interview rooms. If an unmonitored space is used (e.g. too dangerous to transfer), transfer to a monitored area as soon as practicable.
2. For very aggressive patients a mattress on the floor may be safer than a bed.
3. Remove hazardous items (i.e. potential weapons) from the area
Violent or Aggressive Patients in the Emergency Department

Equipment

1. Ask nursing staff to draw up medication
2. If the iv route is preferred, prepare for iv access (18G is preferred), and proceed once the patient is restrained and only if it is safe. If the im route is preferred, or if iv access is not safe, iv access can be considered after the patient is adequately sedated, if indicated.

Positioning

1. Assemble a team. A minimum of 3 staff are required but more should be requested if clinically indicated. Clinical staff are responsible for monitoring and informing the patient, inserting the iv access and administering medication. Staff involved in the restraint should have Aggressive Behaviour Management training, and be briefed on the situation, the plan, and their individual duties prior to beginning the restraint. All personnel to wear PPE.
2. Have a plan for moving the patient from their current location to the monitored bed where sedation will occur. Advise the patient of what is about to happen at the last moment. Be honest and compassionate, but firm. Once the decision is made, avoid protracted “bargaining”.
   a. Most patients will walk calmly when presented with a “show of force”
   b. Two staff holding the arms helps prevent the patient suddenly deciding to fight or run
   c. The patient should be checked for weapons prior to moving (to be done by a nurse or doctor - see MHA, document details of the search)
   d. Very rarely, the patient may decide to “shape up” for a fight. This is a very dangerous situation. Senior staff may then elect to:
      ▪ allow the patient to leave, and contact Police
      ▪ leave the patient there, and call Police to ED for assistance
3. Place the patient on a bed. If the patient is placed face down for added control, the person at the head must continuously monitor consciousness and breathing. An oxygen mask will help to control spitting. At all times the person at the head must be explaining the procedure to the patient, and continuing efforts at calming them verbally. Ensure a patent airway at all times.
4. Do not place the iv cannula until the patient is thoroughly restrained.

(This section left intentionally blank)
Sedation

Practice Point 2:
Where possible, the patient's medical, drug, and allergy history should be ascertained prior to administration of any medication.

Intravenous (iv) route
1. Place iv cannula. Handcuffs may need to be removed. 18G or larger is preferable. Secure very well.

Practice Point 3:
For the intravenous (iv) route, commonly a mixture of a benzodiazepine (eg Midazolam 10mg in 10ml) and an antipsychotic (eg Droperidol 10mg in 10ml).

2. Give I.V. boluses of Benzodiazepine (eg Midazolam 2.5-5mg) repeated every 5 minutes. This may be given together with iv boluses of an antipsychotic (eg Droperidol 2.5-5mg), or the antipsychotic may be added if a ceiling dose of Midazolam (20mg) has been inadequate. Use 2.5mg doses of Droperidol and longer intervals in the elderly. Get expert advice for children and pregnancy.

Intramuscular (im) route
1. Some clinicians prefer the im route, or iv access may be difficult/unsafe. The drug of choice is Droperidol 10mg. Olanzapine 10mg im may be added 1 hour later as required.
2. Once the patient is sedated iv access may be considered, as indicated for safety, blood testing, or further drug dosing.

Both
1. The ideal endpoint is a patient who is calm, drowsy, but able to answer questions, and no longer attempting to leave the bed or strike staff. Avoid over-sedation, which is most common when doses are too frequent. If this occurs it may require definitive airway management. Avoid use of Flumazenil.
2. If the patient remains violent despite sedation, mechanical restraint can be added (see below).

Monitoring
1. As soon as safe, apply oxygen if indicated, acquire an ECG if one has not already been done, & establish non-invasive monitoring (NIBP, cardiac, SaO2). If patient is either deeply sedated or sleeping, consider using an end-tidal CO2 monitor in their Hudson mask, as a form of respiratory monitoring, and lie in the left lateral position.
2. Observations should be q5 min for the first 30 minutes, then q15 min for 30 min, then q 30 min thereafter.
3. This patient requires 1:1 nursing care, until they are fully awake.
4. All patients should be monitored in ED for a minimum of 1 hour.
Violent or Aggressive Patients in the Emergency Department

Safe for transfer to MHU, ICU or Ward

1. Arrange disposition for the patient, e.g. MHU, ward, or HDU.
2. If transferring to the MHU;
   a. The patient must remain in the ED for at least one hour after sedation has been given
   b. The “Medical Clearance Procedure” form must be completed
   c. The patient must have an ADDS score ≤ 3, or a written variation on the ADDS form
   d. A consultant or registrar bedside review must be conducted prior to transfer, to ensure that the patient is safe and suitable for the ward. Particular attention will be given to the level of sedation: that the patient is easily rousable, and also no longer a threat to staff safety. Review must be documented.
   e. Investigations (incl further ECG’s) will be ordered as indicated clinically.

Complications

Staff are to notify the ED consultant, and complete a PRIME CI event.

Patient Care:

1. Excessive sedation with hypoventilation or loss of airway protection – position in left lateral, and consider intubation
2. Hypotension – iv fluid bolus
3. Dystonia (muscle rigidity such as oculogyric crisis, trismus, grimacing, torticollis) – Benztropine 2mg iv
4. Prolonged QTc on ECG (esp >600ms) – rare complication – MgSO4 10mmol iv
5. Neuroleptic Malignant Syndrome – very rare complication with fever, ALOC, muscle rigidity, and autonomic instability.

Documentation

All patients must have documentation of the sedation process: rationale, procedure, and complications.

Mental Health Act – the majority of patients will ultimately be managed under the Mental Health Act 2000, which requires evidence of a mental illness (e.g. self harm, suicidal ideation, bizarre behaviour suggesting psychosis). These patients will require a Request and Recommendation to be completed (by ED), and then an ITO by the MH team. This paperwork is essential and urgent, but should not delay containment of a dangerous situation. The patient may be sedated under the provisions of the GA Act (below), while awaiting formal assessment and paperwork.

Guardianship Administration Act 2000 – management of aggressive patients who do not have a mental illness (e.g. intoxication, head injury, sopsis) is essentially the same, but without the MHA paperwork. The GA Act requires documentation within the patient record, that explains the need for restraint (see “Chemical Restraint” form).

Mechanical restraints

Physical restraint may be employed for the purposes of controlling a patient that is at risk of harming themselves or others, either briefly while treatment is administered (eg oxygen, iv fluids), or to enable chemical restraint as outlined above. In rare circumstances, mechanical restraints (ie ankle and wrist
cuffs) can be employed where chemical restraint alone is inadequate. The following rules must be applied (to comply with Mental Health Act 2000, and Guardianship and Administration Act 2000):

1. Authorised by duty consultant (for Mental Health patients, also notify Director MH by email)
2. Patient notes reflect indication for restraint, authorising consultant, observation frequency, and time when restraint will be reviewed (see reverse of “Chemical Restraint” form).
3. Restraints allow sufficient limb movement to change position for comfort
4. Patient’s need for food, drink, and toileting is met
5. Observation notes record time restraints applied and removed, and name of person applying them (reverse of “Chemical Restraint” form).
6. Any adverse patient event must be recorded in PRIME

A “kit” is available with the restraints, instructions and the observation forms.

Staff Assaulted by Patient

1. Staff member to have injuries managed in ED, including any body fluid exposure, and issue of Workcover certificate. Early termination of shift, and further time off work should be considered.
2. Notify duty consultant and Hospital Coordinator. Also Nurse Unit Manager, Director, and a member of the Hospital Administration (DMS, Executive Director, ADON) at earliest opportunity.
3. An incident report must be completed.
4. Staff member will be supported by line manager in filing of incident report, and making a complaint to Police, which can be directed via the QPS Liaison Officer. Staff will be reminded of the EAS counselling service.
5. All assaults on staff in the ED will be reviewed by the Director and NUM and notified to Hospital Executive, to examine opportunities for system improvement. A formal department debrief may be held where appropriate.
6. The patient involved will have a management plan drafted where appropriate, to warn staff for future presentations, including computer alerts regarding risk of violence.

Legislation and other authority

- Health (Drugs and Poisons) Regulation 1996
- Mental Health Act 2000
- Criminal Code Act 1899
- Health Practitioner Regulation National Law Act 2009
- Guardianship Administration Act 2000

References and Benchmarking

- Guidelines for Acute Sedation in Adult Mental Health Inpatient Settings (2009)
- Mental Health Act (QLD) 2000
- Guardianship and Administration Act (QLD) 2000
Violent or Aggressive Patients in the Emergency Department

- *Workplace Health and Safety Act 1995*

**Related Documents**
- RCKH0028 Code Black – Emergency Response
- RCKH00720 Emergency Lockdown
- RCKH0039 Admission Criteria and Prioritization to the Adult Acute Mental Health Inpatients Units

**Relevant Standards**
- EQuIP National Standards: Standard 15 – Corporate Systems and Safety

**Appendix 1 - Definition of terms**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>TL</td>
<td>Team Leader</td>
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<tr>
<td>ITO</td>
<td>Interim Treatment Order</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>DMS</td>
<td>Director Medical Services</td>
</tr>
<tr>
<td>ADON</td>
<td>Assistant Director of Nursing</td>
</tr>
<tr>
<td>QPS</td>
<td>Queensland Police Service</td>
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<tr>
<td>EAS</td>
<td>Employee Assistance Scheme</td>
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<tr>
<td>PPE</td>
<td>Personal Protective Equipment</td>
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<tr>
<td>OSO</td>
<td>Operational Services Officer</td>
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<tr>
<td>ABM</td>
<td>Aggressive Behaviour Management</td>
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</table>
## Document history

<table>
<thead>
<tr>
<th>Custodian</th>
<th>Director, Emergency Department, Caboolture Hospital</th>
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</thead>
<tbody>
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<td>Risk rating</td>
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</table>
| Compliance evaluation and audit | • Reported PRIME CI events to be tabled at the Emergency Department Service Improvement Group  
• All episodes of mechanical restraint are to be reviewed  
• All reported staff incidents to be tabled at the Emergency Department Service Improvement Group  
• Yearly review of ABM training by Emergency Department Staff |
| Replaces Document/s | RCKHS0744 Violent or Aggressive Patients in the Emergency Department |
| Document replaced | Version 1, February 2012 |
| Key stakeholders | • Clinical Director, Mental Health, Caboolture Hospital  
• Nursing Director, Mental Health, Caboolture Hospital  
• Nurse Unit Manager, Emergency Department, Caboolture Hospital  
• Director Security, MN HHS |
| Marketing Strategy | Publication of procedure on QHEPS |
| Key words | Aggression; Sedation; Safety; Violent; Restraints; Assault; Restraints; Chemical; Mechanical; Emergency |

## AUTHORISATION

Signature: ... Date: ..........................
Director, Emergency Department, Caboolture and Kilcoy Hospitals

## AUTHORISATION

Signature: ... Date: ..........................
Executive Director, Caboolture and Kilcoy Hospitals

The signed version is retained by the Service Improvement Unit.
Appendix 2

Morphine Protocol – Adult

Clinical Relevance:
Patients with moderate to severe pain (including severe burns, trauma, abdominal pain, and chest pain) require early parenteral analgesia. Morphine is a safe drug when used appropriately, and is the standard of care for these patients.

Aim:
Use of a standardised dosing regime for morphine to achieve rapid and effective pain control.

Principles:
Early initiation (within 10mins of arrival)
Significant first dose
Frequently repeated doses
Reliance on patient request, not pain score or patient appearance
Achievement of satisfactory pain control within 30 minutes of arrival

Supporting Evidence:
- Numerous studies shown benefit in early morphine administration in ED patients with severe pain – either nurse or doctor ordered protocols 1,2,3
- Major adverse events are extremely rare 2,3
- Nurse initiated analgesia shown to be safe and efficacious 1,2,3
- Time to analgesia markedly reduced in Australian and international studies 1,2,3,4,5

Inclusion criteria:
- All patients will be offered the Morphine Protocol if they state they have moderate to severe pain or have a pain score 4-10
- Age 16 or above

Cautions (discuss with consultant or *registrar)
- True morphine allergy (extremely rare)
- Home O2 dependent COPD, or presents with severe asthma
- Altered level of consciousness (Eg. Head injury, overdose, intoxication)
- Renal failure
- Hepatic failure
- BP <100 systolic
- Age <16
- Respiratory rate <10
- Pre-hospital morphine or sedative
Procedure:
- Patient identified at Triage, or at anytime during ED stay
- Patient must be on a bed/trolley in the Department (excludes Fast Track)
- Doctor or Nurse charts Morphine as per protocol using preformatted sticker. Sticker placed on front page (once only) of medication chart
- Individual doses recorded as normal.
- Observations (Resps, GCS, Pain Score) at 10 minutes and 30 minutes post administration
- Ask patient if they would like more pain medication every 5 - 10 minutes

Dosing:
- Morphine 0.1mg/kg IV bolus as first dose (maximum 10mg)
  - >65yrs old: initial dose is 0.05mg/kg
  - Had pre-hospital morphine: initial dose is 0.05mg/kg
- All doses thereafter at 0.05mg/kg
- Endpoint: patient declines analgesia or appears comfortable at rest

Who can administer doses:
1. Doctor – can use sticker which details patient’s weight, dose to be given (initial and subsequent) up to a maximum of 4 doses
2. Nursing staff (credentialed) using same sticker but with limitation of standing order for a maximum of 2 doses (initial and one subsequent dose) at which time if further analgesia is required this should trigger a medical review of the patient. See “Standing Order Morphine”

Education:
- Selected experienced nursing staff will undergo specific training package and pass a competency test prior to prescribing morphine as above.
- Hard copies of summary protocol guidelines laminated and displayed in strategic areas eg triage desk, common areas in ED
- Complete protocols to be filed in nursing practice guidelines in ED and clinical nurse educator’s office

Clinical Governance:
- Sign off of competencies by clinical nurse educator ED
- Review of protocol annually
- Audit of adverse events annually
References:


Appendix 3

Procedure

Effective from: October 2014 Review due: October 2017

Assessment and treatment of colleagues and relatives within the Emergency Department (ED)

Whilst it is acknowledged that staff and their relatives actively seek medical attention in the Emergency Department (ED) for a wide range of medical issues, it is a risk prone activity with a tendency to lead to inadequate assessment, treatment and care influenced by non-medical priorities. Specifically; documentation, follow up, disposition planning and reviews can be non-standard due to non-clinical relationship overlays. There is a tendency to avoid asking sensitive questions or perform a full examination when treating colleagues and their relatives. This needs to be actively resisted.

Senior staff are also likely to deliver non-standard care to people they know but will be generally more able to mitigate this risk. Workload issues will limit the ability of senior staff to fully manage these patients, but due to the risks and out of courtesy, senior staff should be involved in such presentations.

Purpose of this procedure

- To provide guidelines for the assessment and treatment of colleagues and relatives within the Emergency Department.

Scope and target audience

This Procedure applies to all Caboolture Hospital staff (permanent, temporary and casual).

This Procedure applies only in the event that a staff member and/or their relative seek medical attention within the ED.

Procedure / process

1. **ALL staff / colleagues and relatives of staff / colleagues seeking assessment and treatment within the Emergency Department are patients of the Emergency Department and shall be:**
   a. Registered,
   b. Assigned an appropriate triage category.
   c. Have their presentation documented as per other patients with the exception that consideration should be given to handwritten notes for presentations of a sensitive nature rather than documentation in EDIS “clinical notes”.
   d. Documentation should include a history of presenting complaint, past medical history, medications, allergies, and relevant system review / examination findings. The investigation results, impression and plan (including disposition and follow up) should also be clearly documented.

2. All Emergency Department staff being treated within the department shall be designated “anonymous” on EDIS. Other hospital staff and relatives should be considered for designation as anonymous on a case by case basis.

3. It is preferable to assess and treat these patients in an appropriate clinical area rather than in a non-clinical area.

4. Where presentations are of a sensitive nature, consideration should be made to hand writing notes and using “medical review” as the discharge diagnosis to maintain privacy. Similarly, these patients may be triaged on EDIS as “medical review” with verbal and hand written communication of presenting complaint.

5. Relatives/colleagues/staff who are seriously ill shall be seen by the senior medical officer on duty though aspect of their care may be delegated to other staff members.
6. The senior medical officer on duty shall be notified by triage of children of staff / colleagues presenting to the Emergency Department and shall be involved in their management and disposition planning.

7. Relatives/colleagues/staff should be discouraged from any form of planned general practice type presentation to Emergency as these presentations tend to require ongoing investigation, follow up and medical ownership of the patient and their problems.

8. It shall be the patient’s decision whether to be triaged and seen in the Emergency department. It is generally unsafe to determine whether someone should be seen or not on the basis of a phone call or corridor consultation.

9. It will be departmental policy that relatives and staff not ask Emergency doctors to request investigations (especially MRIs) for non-emergent problems. It is against the spirit of the Medicare legislation to have Emergency physicians request MRIs except as part of an Emergency work up. Investigations should be requested by the doctor who will act upon the findings of those investigations.

10. Requests for Emergency staff to review staff/relative’s results of investigations requested by other practitioners should be politely declined. Investigation results should be followed up by the practitioner who requested them and understands the clinical context of those investigations.

11. Patients seeking assessment and treatment within the emergency department should stay within the Emergency Department. If they do not need to stay within the Emergency Department then they should generally seek review at their general practitioner. Staff should not leave phone numbers with a request that they be contacted when a doctor is able to see them.

Patient and consumer engagement

ED staff are to provide a verbal explanation to colleagues and/or their relatives that all presentations to the ED will be treated as a general presentation.

Compliance monitoring and outcome evaluation

ED staff who are approached to provide a medical consult outside of the identified triage processes of ED are to report all instances to the Director, Emergency Department.

Legislation and other Authority

- EQuIPNational Standards: Standard 11 – Service Delivery

References and benchmarking