TERM DESCRIPTION

for

Emergency Department

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Contents

***** The Australian Curriculum Framework has been provided with your Rotation Description/Clinical Job Description to be used as a self-assessment tool to identify your strengths and weaknesses and opportunities for learning and professional development. It outlines the desired learning outcomes, although capabilities will be achieved at different stages in your training.

Introduction

Welcome to the Emergency Department (ED). The contents of the Intern & HMO Handbook are designed to assist you with your orientation and role clarification to ED. It is meant as a guide to help get you started and as a reference if you are unsure what to do. It is not a text book, and does not cover medical management of patients. Clinical support and guidance will be given by the Emergency Physicians.

The objectives of the orientation program are:

- To provide information on relevant organisation, administrative, medical, training, staff development, communication processes and staff facilities (Links will be provided in this handbook to guidelines, policies, and important sections of the intranet.)
- To inform staff of their responsibilities regarding standards of service, safety and delivery of care.

Please remember that the ED is the gateway to the hospital and the interface between the community and the hospital. The reputation of the hospital is often made on the basis of care received in the ED.

Senior Clinical team Contacts

For a full list of senior medical staff, please see the notice board in the administration area. Some staff that you will need to be familiar with:

ROLE	PERSON	CONTACT DETAILS
Director of Emergency Medicine	Dr Pauline Chapman	Extension 96455 Paulinec@bhs.org.au
Director of ED Nursing	Grant Berriman	Grant.Berriman@bhs.org.au Extension 96455
Deputy Director ED	Dr Mark Hartnell	Mark.Hartnell@bhs.org.au
Emergency Administration	Fiona Hodder / Naomi Bailey Lisa Gowers	EmergencyAdministration@bhs.org.au Extension 96455
EMET Program support officers (Medical Education)	Mary Drendel	Mary.Drendel@bhs.org.au
Director of Emergency Medicine Training (DEMT)	Dr Rajesh Sannapareddy Dr Aaron Robinson	Rajesh.Sannappareddy@bhs.org.au draaronrobinson@gmail.com

Director of Short Stay Unit (SSU)		

Orientation

Orientation will be conducted at the beginning of your rotation by one of the Consultants. Notification will be sent, via email, with the time and location.

What you need to know before your first shift

BE familiar with the management structure in the ED. We have provided Staff Profiles so you will be familiar with the senior staff in the Emergency Department. (See displays in the administration area of the department)

Contact the ED Administration Manager, 96455, Fiona Hodder/Naomi Bailey or Lisa Gowers : They will send you a link to the information required, arrange orientation time, lockers, and get your contact details (it is essential that we are able to contact you) Check your roster, turn up to your allocated shifts

DO attend work wearing **identification badge/swipe card**: which should be obtained from Human Resources at the commencement of your employment. You will also need passwords for IBA, as well as BOSSNET. (If you have been working elsewhere in the hospital, you need to have your password linked back to ED for access to the ED screen of BOSSNET.)

DO attend refreshed and appropriately dressed. Scrubs can be accessed in the hallway, but are not compulsory. If not wearing scrubs, then please be clean, neat and modest. Avoid wearing anything that maybe grabbed by patients.

Where do I Start?

Report to the Admitting Officer at the start of each shift.

- **DO** understand the supervision requirements and arrangements for junior medical staff in the ED.
- **DO attend ED Handover**:
    - *Formal handover at 8.00 a.m*. This handover takes place in the main staff base and all night staff should attend. Depending on workload, the AO will decide which day staff should stay for handover, or be allocated a new patient.
    - *Formal handover at 10.30pm* to night staff. Same as for morning handover.

- Every attempt should be made to have key decisions and referrals made prior to shift changes. Interns are not permitted to receive handovers from other staff.

- **DO pick up the next patient waiting to be seen, in the correct order.**
- **Admission of patients**: be aware that we need to make early decisions regarding patient admissions and this should generally occur before waiting for results. Always discuss referrals, discharges and investigations of patients with a senior ED doctor when you start. Document this on the ED chart.
- **DO clean up after yourself – not all cubicles** have nursing staff allocated to them. Doctors are therefore responsible for checking and **cleaning** these rooms. Check a room first before taking a patient into it, dirty cubicles are a common source of complaints.
- **DO locate the** nursing allocation board so you can direct requests to the appropriate nurse. Understand what the charge nurse and triage nurses do.
- **DO** have a meal break: the standard allocation is 30 minutes per shift. Unlike nursing staff, this is paid time, therefore you need to be accessible during this time, the AO must know where you are and any unstable patients must be handed over.
- **DO** know how to dispose of sharps, be aware of policies on disposable equipment, and know what to do with non-disposable items after use. Scalpels **must** be disposed of in the sharps bin, and are not reusable.
- **DO** commit to an excellent standard of clinical documentation and clinical reasoning for;
    - Pathology and radiology requests (MUST have clinical notes or the tests may be refused or not reported)
    - Prescriptions and drug orders
    - Clinical notes and ensure our combined clinical notes are mostly at the bedside.
    - Checking the results of all ordered tests, **including flagging and sign-off**.
    - Referral documentation to GPs and outpatients
    - Medical certificates

- **DO** know how to find the Policy and Procedures Manual and clinical guidelines in the intranet, and use this guide for information not necessarily written in guidelines or textbooks, for example:
    - **Blood Alcohols in Road Trauma**: be aware of your legal responsibilities in this area. Refer to section 14.
    - **Blood transfusion policy.** Also see section 6.
    - **Visitors**: be aware of our visitor policy and the need to escort all visitors into the department. This changes frequently due to COVID.
    - **Phone enquiries**: ACEM and BHS policy mandates that only first aid advice is given over the telephone. Requests for clinical advice to be diverted to NURSE ON CALL. We are **all** responsible for answering the

phones in the department. Do not use the ambulance phone for phone calls or paging staff. If it rings, then leave it for the triage nurse to answer. The AO phone should only be used by the AO, but if it is left unanswered, then please pick it up and find the AO.

Sick Leave: Medical Staff are advised to phone the AO on 5320 6455 to report sick leave or unplanned absences. Refer such calls to the AO. Registrars in charge overnight must report sick leave to the AO at the first opportunity. If you are sick on a weekend, as well as calling the AO you also need to notify Medical Workforce On Call via switchboard, so that a replacement can be organised if needed.
Staff are advised not to notify sick leave by email. If sick leave is expected to extend beyond two days then an email to the Administration Manager is reasonable after it has been reported to the AO.

DO attend Education sessions: occurs Wednesday afternoons for registrars and Thursday afternoons for HMOs / interns (see section 13). ***Emergency Medicine is more enjoyable when you know what you are doing***.

We have provided a list of red flags and 'DO NOT MISS' diagnoses.

Red Flags in the ED

The following list is based on local issues and well known situations published in books relating to medical errors. Red flags are features of a patient's presenting symptoms which flag a potential life threatening situation.

1. Women of child bearing age with abdominal pain or PV loss = ectopic pregnancy until proven otherwise.

2. Atypical chest pain is ischaemic heart disease until proven otherwise.

3. Unexplained dyspnea = consider pulmonary embolus (use Well's criteria).

4. Renal colic + age >50 = ruptured abdominal aortic aneurysm until proven otherwise.

5. Sudden onset of severe headache = subarachoid haemorrhage until proven otherwise (even if headache has resolved, this may be a herald bleed).

6. Exclude FB and underlying damage (eg tendons) in all wounds.

7. Head trauma including falls + alcohol/drugs or blood thinning agents = traumatic brain injury until proven otherwise (preferably using CT).

8. Head trauma = cervical spine trauma, and proven cervical spine trauma = another spinal fracture in 10% of cases.

9. Chest pain + neurological symptoms = consider aortic dissection.

10. TIA + fever or murmur = consider septic emboli and endocarditis.

11. Back pain + fever or recent procedure, or past malignancy = consider serious rate causes e.g. epidural abscess, metastatic disease.

12. Psychiatric symptoms + fever, delirium, or visual hallucinations = consider organic cause.

13. Given the rapid onset of the disease any patient presenting with a petechial or purpuric rash and fever should be assumed to have meningococcal septicaemia until proven otherwise.

Remember that patient care is reviewed for a variety of reasons, from complaints, audits, coroner's cases and when medico legal issues arise:

1. Prevent errors: please remember - **IF unsure WHAT to do - ASK a senior clinician**.
2. Documentation: write good **AND** legible notes. Remember you may have to recall things five years later!
3. Handover errors are over represented. A senior ED doctor should be aware of all patient handovers. We are responsible for the patient whilst in ED.
4. Have a senior medical officer review all children < three months and have junior medical staff discuss all cases before discharge age < two years.

What We Don't Do

At the risk of sounding like complaining, we would like to outline at the start of this manual a list of things that ED does not do, to save wasting a lot of time.

- *Reviews*: this is to be discouraged; most patients should be referred back to their local doctor with a letter. Exceptions may include eye injuries and x-rays from the night before. These patients should be asked to arrive early in the day ~8.00 to 9.00 a.m. as it is *generally* quieter. It is not recommended that you give out results over the phone.
- *Reviews of fractures*; either first or final review, and routine removal of plasters.
- *Routine prescriptions*: patients requesting these should be referred back to their GP or appropriate specialist.
- *Forensic tests* (other than blood alcohols in traffic accidents).
- "*Medicals*" for insurance, diving, industrial, visa or similar purposes.
- *Contraception* (other than provision of the 'morning after pill').
- *Travel* medications and vaccinations.
- *Routine immunisations*.
- *Witnessing* of passports or other official documentation (except TAC forms).
- *Authorising prescriptions* for ongoing supply of drugs of dependence (this is illegal as patients receiving these drugs should have only one registered prescriber).
- *Pap smears*; this is not an emergency investigation. We do not have a reliable way of following up these results, and abnormal results can easily get lost. If a patient requests one, then please advise them to see their GP. Smears done by the GP are generally sent to the Victorian Cytology Registry, who have a system to help follow up. Tests done in ED go to Dorevitch who have no such system. Results are not placed on the consultant watch list so unless you look for them, no one can check them.

Patients presenting to ED 20 or more weeks pregnant are referred directly to the obstetric ward 5 North. This is because a wide range of problems, including seemingly unrelated symptoms such as headache, visual disturbance, or dyspnoea, may be a complication of the pregnancy.

Exceptions to this are covered in a clinical governance document, but include.

- Trauma in pregnancy.
- Conditions unrelated to the pregnancy; e.g. cut fingers.
- Imminent delivery (better to deliver in the ED than in a lift).
- Any patient whose condition is deemed to be unstable. These should stay in the ED and if necessary obstetric staff called down to attend to them here.
- Contagious patients including diarrhoea, but not including simple URTI's

Layout of the Emergency Department

Please note, the ED has undergone a re-structuring since the onset of COVID-19. The comments in red are due to COVID and may be temporary.

1. Triage

This is the area where one of the senior nursing staff assesses and prioritises all patients on arrival. It is a very busy and stressful area so please only visit if essential, and don't interrupt the triage nurse unnecessarily. Currently, the front of house triage is for patients walking in off the street, as well as SCOVID (Suspected COVID) patients arriving via ambulance. A second triage has been set up at the back entrance for all other ambulance arrivals.

2. Reception

After Triage, patients will next be directed to the reception area. Staff here will obtain information to develop ED notes, retrieve histories from health information and complete admission forms (front sheets).

3. Waiting Room

If treatment is not required immediately and patients are stable, they will be asked to remain in the waiting room, (either general waiting room, or SCOVID area), until they are called. Here they can be assessed by the triage nurse on an ongoing basis as required.

4. Fast Track and internal waiting room

The fast track area is a clinical area where low acuity patients with simple problems can be seen quickly and their management expedited. It consists of five cubicles with a separate staff base/write up area. Staff will be allocated to this area by the AO at the start of each shift. (Refer to separate section.)

The internal waiting room is used for patients from fast track, who are clinically stable and able to sit, and who are waiting for things such as results of tests, or review by an inpatient unit.

Please be aware that there are only one or two nurses allocated to Fast Track. This means that, according to patient ratios, they are only allowed to look after 3 patients each, ie. Fast track bays 3 to 5, and the internal waiting room. At times when there is only one nurse, fast track bays 1 and 2 will not be nursed. If you have patients in these bays and they need observations, medications or dressings done, you should speak to the nurse in charge.

5. Bays 1 - 2

Non-monitored bays, but oxygen and suction are available in each bay. Bays 1 – 2: used for patients with minor complaints that do not require monitoring, but may need to lie down e.g. patients requiring IV therapy or drugs, fractures, major dressing changes etc. These bays are equipped with toys and mobile television/video for children. Baby scales are located outside bay 17. These rooms are utilised for children that do not require monitoring. If a child is particularly unwell, they may need to be transferred to a bay that is closer and more visible to the work station. Just because they are children does not automatically mean they will be in these two bays!

6. Bays 3 - 11

Monitored bays with wall oxygen and suction available.

The most visible from the central work station and closest to the resuscitation rooms in the event the patient deteriorates. We try to allocate these bays to the sickest patients who don't require the resuscitation room.

Bay 4: is well visualised from main staff base and therefore useful for patients with mental health or behavioural problems. There is a grey duress alarm on the outside wall and room for security.

7. Resuscitation Rooms One - Three

Three bed resuscitation area, separated by a curtain, fully equipped and used to care for category one patients e.g. cardiac/respiratory arrest, multiple trauma etc.

Resuscitation room 2 is more specific for paediatric resuscitation as it has the paediatric intubation trolley in it.

Resuscitation room 3 is utilised for resuscitations if very busy but is mainly used for major procedures such as Biers Blocks, Lumbar Punctures, ICC insertion, ketamine sedation, pleural taps etc.

8. COVID area Bays 12 – 17, 19 – 21, Minor procedure area

These bays currently form our COVID area. All patients with respiratory symptoms, a fever, or someone who is unable to answer the screening questions at triage (eg unconscious patients), will go to the COVID or respiratory area.
Bays 12 – 17 are nursed as per usual patient ratios.
The minor procedure room is set up for HDU type patients (one to one nursing).
Bay 20 is set up as a resus bay. This is the only bay with negative pressure ventilation.
Bays 19 and 21 may not have nursing staff allocated to them, so please do not put patients requiring nursing input in here.

9. CIN area

The Clinical Initiatives Nurse (CIN) is able to rapidly assess patients in the waiting room, and commence treatment. They will often request that medical staff prescribe certain medications or order tests, to save time when the patient is picked up by a doctor. Please assist the nurse by listening to and complying with their requests. This function currently takes place in the Internal waiting room.

10. Ambulatory Emergency Department, Bays 1 - 7

This is a new area with 7 treatment rooms, designed for rapid assessment and treatment of straightforward patients, that should be discharged within an hour. If working in this area, you will need to keep watch on the main waiting area, and 'pull' appropriate patients across to the AED. The AED is only open between 10.00am and 9.00pm.
Currently the equipment for eye examinations, and plasters and splints are located in the AED. It is important, for infection control reasons, to clean the slit lamp with alcohol wipes supplied (and document this in the audit book located in the room) before each patient.
Also, as the eye equipment is located in AED, it may need to be used outside of these hours for eye examinations. If needing to go to the AED overnight, please consider taking an escort with you for security reasons. Do not take patients with a history of violence and aggression (black triangle).

11. RAV Corridor

Due to 'Access block' across the hospital, often the entire ED will be full of patients, blocking the incoming ambulances from being able to unload their patients. These patients will wait in the 'corridor' after being triaged, with the ambulance officers, who will provide ongoing care. It is still possible for us to assess these patients, take a history, order investigations, or provide medications to these patients while they are waiting, in order to expedite their care once they are moved to a bay. Please keep an eye on the screen for who is waiting in this queue, but also remember to respect their privacy whilst in the corridor.

Short Stay Unit

The Short Stay Unit is a 12 bed unit designed for admissions less than 24 hours. It is set up like a hospital ward for inpatients, with its own staff base separate to the rest of the ED. Staff rostered to this area will attend the ED to facilitate efficient patient transfers and discuss potential patients with the Admitting Officer. Short stay medical staff are

expected to assist in fast track if the ED is busy and/or they have no jobs to complete in the SSU. (There is a separate manual for SSU and all staff are expected to be familiar with the clinical pathways which contain admission and exclusion criteria.) The clinical pathways are found on the intranet by a search for "useful forms", or available with the SSU guide in the Emergency Department Orientation folder on the shared (S:) on each computer.
All admissions to SSU need to be authorised by one of the ED consultants (or the AO overnight). Once accepted, a pathway needs to be completed, with a specific plan, and the patient needs to be handed over to the nurse in charge of SSU (and the SSU doctor) on 94415 or their mobile phones. The AO overnight can admit to short stay without consultant approval but must not use the generic pathway. The ideal Short Stay patient is one who is ambulant, and stable, who is almost certain to go home within 24 hours, with a period of intensive treatment/observation.

Clinical Responsibilities and Tasks

How do I know who does what and who do I ask for help?
The following is a list of regular staff who work in ED. There are many other staff who visit as well.

Medical Staff

- **Emergency Physicians**

On most days, there will be three to four ED physicians rostered on morning and evening. The AO consultant (alternatively called 'admitting officer') will be the one in charge for each shift. This doctor will occupy the 'AO' chair, use the main computer in the middle of the staff base, and answer the AO phone. Please leave this computer free for the AO. This is the doctor you should approach if you need any advice for patients in bays, or need to update them with what is happening with your patients. One consultant will be allocated to COVID, and the third and/or fourth will be allocated to either Fast Track, AED/SSU or Resus depending on work-load and staff mix. Please discuss all patients in each area with the relevant consultant.

Registrars and HMOs

Our Emergency Department is accredited for basic and provisional training, and for 12 months advanced ACEM training in the ED. The ED registrars also rotate to other areas in the hospital, particularly ICU and the anaesthetic department.
In any shift there will be a number of Registrars and HMOs working. Overnight a senior registrar will fill the role of the AO. They are expected to manage patient flow and supervise the other medical staff working, including giving advice.
One registrar on each shift will be allocated the role of resuscitation registrar.

- **Interns**

The ED is a good area to learn a great deal of general medicine, general surgery, paediatrics etc and as such is an important rotation in the first year. As with all rotations, interns are supervised at all times. However, they are encouraged to see patients independently initially and then to discuss with a senior doctor. For this reason we have some guidelines to minimise/eliminate the risk of clinical errors.

1. Interns must discuss all patients they see throughout their entire rotation, who must then be reviewed in person by a senior doctor prior to discharge.
2. Prior to calling unit registrars/consultants about admissions or advice, all cases must be discussed with the ED physician/Admitting Officer.
3. If in doubt about anything (medical, organisational or investigational) ask - preferably early.
4. Interns cannot order ultrasound, CT or X-rays with contrast without first having discussed this with a senior doctor.
5. Don't take on too much too early. As your skills develop you will be able to do a few things at once.

Nursing Staff

- **Critical Care Nurses**

The majority of nurses in the department are "critical care trained"; have years of experience in emergency nursing and are a valuable source of advice. Whilst many can insert IVs, it is not their responsibility to do so and if they are too busy or unable to do so for any other reason you will have to do it yourself.

During any shift, one nurse will be in charge, one or two nurses will be responsible for triage, one will be a 'navigator', and the remainder will be assigned to a particular area within the department.

The nurse in charge or navigator will be able to assist you if any of your patients require admission. Please keep them updated with what is happening with your patients, as well as the senior doctor, as they are both responsible for flow of patients within the department.

If assistance from a nurse is required, the white board in the main staff base will tell you which nurse is responsible for your patient. Please communicate with the appropriate nurse regarding your patient at all times. If the nurse assigned to your patient is busy, then speak to the nurse in charge of the shift.

- **Clinical Support Nurses**

On some shifts, one of the nurses may be assigned to 'clinical support'. This is essentially a non-clinical role and they are not available for patient care, unless extremely busy.

- **Navigation Nurses**

On most daytime shifts, one nurse is rostered on as the 'Navigation Nurse'. Their role is to assist with the flow of patients. If they ask questions about your patients, please assist them. They are not questioning your judgment, but trying to assist with movement of patients. Please them know as soon as possible once the decision to admit a patient has been made.

- **Triage Nurse**

All patients are assessed by the triage nurse on arrival and given a triage category according to the National Triage Scale:

- **COVID Runner**

One nurse in the COVID area will be assigned as a 'runner'. This nurse has a similar role to the nurse in charge, and is available to assist staff whilst in PPE.

The Australasian Triage Scale (ATS) is designed for use in hospital-based emergency services throughout Australia and New Zealand. It is a scale for rating **clinical urgency** and determining the order in which patients are seen**.** It does not necessarily equate to severity of illness or prognosis, so waiting times for all patients need to be kept to a minimum.

Although primarily a clinical tool for ensuring that patients are seen in a timely manner, commensurate with their clinical urgency, the ATS is also a useful casemix measure. The scale directly relates triage code with a range of outcome measures (inpatient length of stay, ICU admission, mortality rate) and resource consumption (staff time, cost). It provides an opportunity for analysis of a number of performance parameters in the Emergency Department (casemix, operational efficiency, utilisation review, outcome effectiveness and cost). As the ATS is a primarily clinical tool, the practicalities of patient flow must be balanced with attempts to maximise inter-rater reproducibility.

National Triage Scale	Colour	Treatment Acuity
1. Resuscitation	**Red**	Immediate
2. Emergency	**Orange**	Within 10 minutes
3. Urgent	**Green**	Within 30 minutes
4. Semi-urgent	**Blue**	Within 1 hour
5. Non-urgent	**White**	Within 2 hours

- The triage nurse takes incoming phone calls regarding notification of incoming ambulance patients and is advised by the AO regarding referrals from GPs, other hospitals, and residential care facilities.
- The triage nurse liaises with the shift co-ordinator, medical staff and clerical staff to maintain an organised flow-through of patients.
- The triage nurse is responsible for patients in the waiting room.
- The Triage nurse will announce on the paging system all category one and two patients.

Other Staff

- **ED Administration Managers**

The Administration Managers to the ED have a very diverse but important role in assisting the Director and Nurse Unit Manager with the smooth running of the department. You can assist by communicating with the Administration Managers to avoid inefficiencies and completing work certificates on time. In particular, the Administration Managers are responsible for the following:

1. Creation of the medical (HMO) rosters, changes and notification to staff.
2. Communication with the Director and Nurse Unit Manager regarding distribution of information to staff.
3. Organising appointments with the Director and Nurse Unit Manager.
4. Checking roster-on and ensuring the correct information reaches pay office on time.
5. Liaison between Director, Nurse Unit Manager and staff.

- **Technicians**

Technicians are on duty for ED 24 hours each day. They also look after the helipad which takes priority over ED roles. If there is an imminent helicopter landing, then other requests will have to wait. For non-urgent requests, there is a whiteboard in the second staff base. The technicians' roles include the following:

- Apply plasters, splints and fit crutches.
- Removal of rings in finger injuries.
- Assist with patient transfers to X-ray, CT wards etc.
- Assist in positioning of patients in the department.
- Assist as required in resuscitation area.
- Assist with retrieval of patients from cars etc.
- Transport some pathology specimens (e.g. urine samples) to the appropriate place. Most blood samples can now be sent to pathology via the chute.

- **Physiotherapy**

There is currently no physiotherapist available within ED. Ward physiotherapists may be contacted via the internal paging system. They are unable to manage acute injuries or back pain, but may be able to asses if your patient is safe to mobilise in order to go home.

- **ED Care Co-ordination (EDCC)**

A 'Care Co-ordinator' is available in the department full time, from 8:00 a.m. until 4:30 p.m 7 days a week. . Otherwise a referral can be made for the EDCC to follow up the next day, using the green 'After Hours' form in second staff bay.
The aims of the EDCC position are:

- Work as a team member to ensure comprehensive assessment and intervention of patients who are aged, those with complex social or medical needs, identify

risk factors which may impact on a safe discharge, and/or who are at risk of multiple presentations to the ED.
- Facilitate with safe and timely discharge from ED, care planning, liaison with existing service providers and facilitation/referral to services (including other allied health, hospital, community programs and community service providers). When suitable EDCC will seek alternatives to hospital admissions for those with no medical need for admission.
- The EDCC will work with families and carers as appropriate (including families in need in resuscitation cases).
- Provide a post discharge follow-up phone call service via your AH referral, with the aim of reducing unnecessary re-presentation to the ED (Use green referral form in second staff base).
- Provide point of contact for community service providers within the BHS ED.

If unsure, ask!.....0401 048804

- **ED Pharmacist**

A pharmacist is now available in ED from 8am till 5pm, Monday to Friday, or on pager #4729. The pharmacist's main role is completing BPMH (Best Possible Medication History) for patients to be admitted, and checking against charted medications where applicable. This is performed mainly for patients identified as high risk, or on staff referral.

Other roles for the pharmacist include:
- Attendance on ward rounds (8AM medical staff handover)
- Advice on dosage adjustment in liver or renal impairment
- Assist in 'Adverse drug reaction' (ADR) documentation and reporting
- Therapeutic drug monitoring
- Patient education
- Medication chart review (for admitted patients)
- Non-imprest medication supply
- Discharge planning and liaison between the hospital and community
- Drug information and education for medical, nursing and allied health staff

- **Program support officer**

BHS ED though ACEM funding has become an Emergency Medicine Education and Training (EMET) Hub. As a part of this we now have a Program Support Officer (PSO) (Part-Time 0.6 EFT).

The primary purpose of the Program Support Officer position is to assist candidates and their supervisors enrolled in ACEM's Emergency Certificate and Diploma Program and IMGs participating in ACEM's educational activities.

The PSO also coordinates the Emergency Department education programs for interns, HMOs and Registrars and maintain the online education resources

(http://educationresource.bhs.org.au/emergency).The Program Support Officer is responsible for the scheduling training sessions and informing doctors of the training program, through email and an online calendar (http://educationresource.bhs.org.au/emergency/calendar).

The BHS Medical Education App for smartphone provides the schedule and topics for each upcoming week's ED HMO and registrar teaching sessions and can be downloaded at https://bhseducationseries.shareableapps.com/

Useful hospital-wide education and orientation packages can be found at http://ballarat.e3learning.com.au/ (username: your payroll ID number, password: Ballarat1)

The Program Support Officer also assists with the IMG Observer Program within the ED and in linking other hospitals in the region into our training program

- **Reception Staff (see above)**

Staff here ensures relevant information is entered on the Patient Administration System for every patient. They work for the Heath Information Services and perform an invaluable role in the ED. They are involved with ED medical records, retrieve histories from health information and complete admission forms (front sheets). It is worth remembering that as the ED attendances increase, so does their workload. Written charts will remain in the ED reception until sent to HIS to be scanned (usually within 1 to 2 days), and are then sent destroyed after scanning.

- **Ward Clerk**

A ward clerk is available each day to help primarily with restocking of trolleys, medical forms and documentation, store room etc, as well as organising repairs and helping with rosters.

- **Ward Assistants**

Ward assistants have a similar role, as well as transporting specimens to pathology, and cleaning of beds, and the tea room (but they are not there to wash your dishes after a meal!).

- **Volunteers**

BHS ED does not currently have further volunteers until further notice.

(BHS provide a number of volunteers who dedicate their own time to patients, relatives and friends using ED and we appreciate their efforts.
Their role includes supporting patients, family, and friends during typically busy times in ED. They are not nursing staff and should not be requested to perform nursing duties. They should check with medical and nursing staff before feeding patients to make sure they are not fasting.)

Rotation Objectives

Interns/HMO

Clinical Management

- Develop the ability to take a thorough history, examination and carefully consider each patient's needs for presentation to the appropriate colleague. This will include work BOTH in the ED and the wards.
- Develop the ability to recognize the unwell patient, seek appropriate senior assistance and to initiate relevant testing and instigate immediate management for common medical conditions.
- Establish your role in a team structure with medical and nursing colleagues.

Communication

- To make detailed notes on all patients and discussions with senior medical staff.
- To develop effective and accurate communication between in-patient teams and other health professionals.
- Regular communication with the patient and/or their families where relevant.

Professionalism

- Punctuality whenever possible with organization of priorities expected.
- Probity and confidentiality are expected. Note that confidential (blue) bins are to be used for disposal of any patient identified material (including handover sheets).
- Support for your colleagues, junior and senior, should be maintained at all times.

Clinical Procedures

- A range of practical procedures will be expected to be developed by repetition under supervision.
- Examples include basic resuscitation routines, suturing, insertion of intra-venous cannulae, direct lumbar puncture, urinary catheterization,
- Diagnostic aspiration of joints, pleural cavity/abdominal cavity and
- Other more difficult procedures as the opportunities present

Registrars

Clinical Management

- Develop your diagnostic skills and decision making
- Develop your management of competing time pressures by delegating activity to your team
- Taking control of admissions flow and acute diagnosis and management
- Take the opportunity to be involved in a diverse range of needs surrounding patient care.
- You are expected to perform at a high level of clinical skill appropriate to your ongoing training. This will involve:

    - managing resuscitation teams to ensure DIAGNOSIS is clear and OUTCOMES are optimal and appropriate to the setting,
    - Ensuring appropriate resuscitation and medical emergency status is reviewed and discussed regularly
    - facilitating transfers of patients,
- Review and present the literature on interesting common or rare conditions especially as they relate to patients of the unit. The library and internet services are available for this purpose.

Communication

- You will act as a medical coordinator with tertiary hospital colleagues where relevant
- Discussions with community colleagues in both Ballarat and the region
- Counseling of patients and their families regarding medical aspects of diagnosis and treatment in conjunction with nursing staff

Professionalism

- Punctuality and consideration for the patients and all those involved in their care
- Probity and confidentiality are expected. Note that confidential (blue bins) are to be used for disposal of any patient identified material (including handover sheets).
- Support for your colleagues junior and senior should be maintained at all times.

Clinical Procedures

- Opportunity to continue to develop your basic procedural skills, practice new procedures or in acute settings and supervise and guide interns and HMOs in their performance of routine tasks involving minor procedures.

Performance Appraisals

The Performance Appraisal Form for Junior Medical Staff was revised in 2014 to bring it into line with the Australian Curriculum Framework for Junior Doctors (ACF). This will now allow assessment of the knowledge, skills and behaviours identified as necessary for Junior Doctors to work safely in Australian hospitals.
The assessment criteria cover the following three areas:

- Clinical Management
- Communication
- Professionalism

Before commencing work you will be sent an email with the staff development plan, and paperwork for performance appraisals.
We ask that you fill in the staff development plan before coming to orientation; this allows us to know what it is that you wish to get out of your rotation here.

INTERNS & HMO – what to do during your rotation

- Appointments should be made with your allocated term supervisor before the end of your rotation. (You need to fill in self-assessment before appointment.) References are based on performance appraisals so please ensure they are completed. They can also be done at any time before this if you request, or if the consultant staff have any concerns regarding your performance
- Goal setting including fire and safety, resuscitation competence (compulsory for registrars before nights, strongly recommended for HMOs), and education should be completed at the beginning of your rotation.
- When you start your rotation you should receive a 'Self Directed Learning' Workbook. You should aim to complete as much of this book as you can and bring it to your appraisal for discussion and assessment.
- Have regular discussions with colleagues
- Add interesting cases to your consults list in BOSSNET, to facilitate discussion. This ensures you do not need to keep lists with patient information, which if taken off site can result in privacy and confidentiality breaches
- Keeping a logbook or journal can assist with reflective practice.

Formal discussions with the Term supervisor or consultant in the middle and at the end of the rotation

The national intern assessment form is well designed and self-explanatory and available here. This form is being introduced in 2014. In 2015 it will be mandatory for intern rotations and will be introduced for HMOs.

We expect professional communication from our senior staff and for the junior staff to work in an environment that is supportive, with a culture that does not include any bullying or intimidation. You should expect that you are a valued member of staff, and that you are entitled to learn while in the department.

Understanding the patient's journey through the department

How do patients arrive at the ED?

Referral / 'Admitting Officer' Calls: The 'AO' Phone

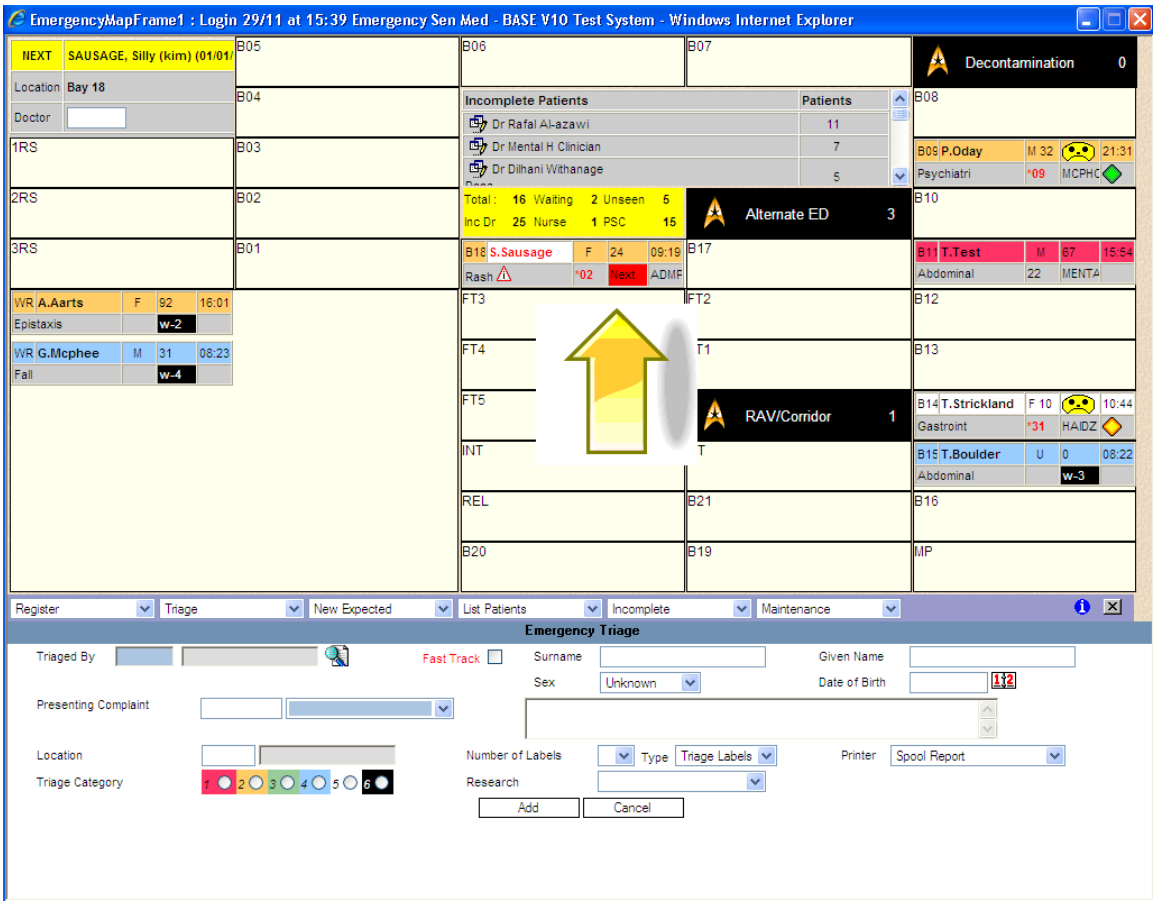
Many GPs refer patients to ED through the AO phone, mainly those that are out of Ballarat. These calls must be taken by the Admitting Officer as this is a clinical handover to the most senior doctor (usually ED physician or ED registrar after hours) to determine if it is appropriate to send the patient to Ballarat, or if an alternative destination is better. A dedicated portable phone (94801) is available for this purpose. The AO answering calls should take down the relevant details and clinical notes, which are entered into IBAPAS, so please read this. Most Ballarat GPs will simply send their patients to ED with a letter, since it is less likely we would say no to these patients. If the problem is less acute e.g. a request for outpatient reviews, it may be more appropriate to refer the call to the relevant inpatient registrar.

Calls concerning inter-hospital transfers of admitted patients should be referred to the bed manager (PFC) as well as the relevant unit registrar. These patients may be directly admitted to a ward bed or seen in ED, dependant on bed availability, patient condition, and time of day (see separate policy). If the patient is deemed unstable, then they should be seen in the ED first for stabilisation and to determine the appropriate ward.

Triage

Most patients however, arrive unannounced, either by private car, or ambulance. These patients will be assessed by the triage nurse on arrival, who will decide the triage category and which area of the department to send them to. Generally the low acuity patients will remain in the waiting room, to be seen in fast track, and the sicker patients brought into a bay in the main department.

How do I know which patient to see next?



The AO will allocate which area you are to work in each shift. Please report to the AO, and check the allocation board at the AO desk at the start of each shift to see where you are required to work.

In each area, the computer will tell you who the next patient to be seen is. This is done in order of priority according to triage category, followed by time of arrival if more than one patient of the same category. You need to see the patients in order, and not just cherry pick the ones you want to see. This includes delaying picking up a patient, and putting your name down next to a patient when you are not ready to see them immediately. A large yellow arrow above helps find the box marked.

Why are the names in red sometimes?

In the example of IBA above, you can see the name 'S.Sausage' is in red, on a white background.

This means EITHER that there are 2 patients with the same surname OR that the patient is re-presenting within 48 hours.

If it is a returning patient, then these ones MUST be seen by a senior doctor – registrar or FACEM – as sometimes these patients may have deteriorated, or the diagnosis was incorrect the first time.

How do I pick up a new patient?

Check the computer for patients waiting to be seen. Before going to see a patient, put your name against that patient on the computer so that other staff are aware of who is waiting. In order to do this, click on the patient who is next in line to be seen and their details will come up at the bottom of the MAP screen. Enter your specific code in the white box just to the right of where it says 'Doctor', then click on the icon to the right of this with the magnifying glass on it. (See above MAP) This will record the current time as when you went to see the patient. For patients in the waiting room, this should be done at triage (or fast track), as you are about to see the patient, and not from the main staff base.

This is important for auditing purposes so that the 'time seen by doctor', accurately reflects when the patient was seen. It also avoids the situation where doctors put their name against a patient, then get distracted by another problem before seeing them, thereby causing a delay (and potentially another patient behind them in the queue could get seen first by someone else). If the situation arises where you have put your name against a patient but have not actually seen them in a certain time frame, we have empowered the triage nurse to remove your name from that patient. Picking up the patients at triage also allows the triage nurse to pass on important information to you that may not be contained in the usual notes, before seeing the patient.

Nursing staff are empowered to get senior medical officers and nurses to "quickly see" straightforward and simple cases in the fast track area, to expedite their care e.g. suture removal, dressing changes, tetanus requests, plaster checks etc.

Fast Track, CIN (Clinical Initiatives Nurse), AED and RATT

Fast track and AED are a relatively new model of care within ED which aims to provide an efficient and effective way of caring for people who present to ED with minor illnesses and injuries within a purpose built area of the ED.

The fast track area is behind triage and has five purpose built cubicles, three of which will have a dedicated nurse to assist with management. A dedicated staff base with all required paperwork and medications is co-located and trolleys have all equipment needed to treat minor injuries thus reducing time spent looking for equipment/scripts/paperwork.

Typically patients who present with lower acuity conditions wait whilst those with higher triage categories are seen first. In the past, category four and five patients have been labelled as 'GP type" patients but within this group are patients with complex conditions, many of whom are admitted. All are entitled to care within ED but often long waits, particularly after-hours, result. Patients suitable for fast track include minor injuries (sprains, fractures and open wounds), ENT complaints, eye injuries, IDC replacement, UTIs and URTIs. As with other areas, fast track has inclusion and exclusion criteria; the exclusion criteria generally includes any reason that the patient may need to stay for more than one hour, e.g. the elderly or those with social problems. Putting these patients in Fast Track may block those cubicles, meaning that there is nowhere to see the real fast track patients.

Fast track further assists in streamlining patients so that those with simple, non-urgent or non-life threatening illnesses/injuries are seen in a separate queue from the mainstream patients with more complex medical issues or serious illnesses. Patients may be further streamlined in fast track as needed e.g. quickly order x-ray for ankle then see child with bead in nose whilst waiting for x-ray to be done. This is NOT what occurs for the rest of the department as patients need to be seen in order of triage.

CIN: This nurse is able to assess patients who are in the waiting room, to commence management ahead of being seen by a doctor. This means that sometimes, by the time you get to 'pick up' patient, they may already have some results available, as well as having their pain under control, which will expedite your management. Please assist the CIN nurse, if they approach you requesting some analgesia or Xrays.

Patients are NOT triaged to Fast Track, so some flexibility and common sense is required in determining who is seen there and in what order. It is unethical for fast track to result in patients with less acute problems having substantially lower waiting time than sicker patients, In general the patients should be seen according to the NEXT in line by the rest of the medical staff.

Staff will be rostered to this area and will have consultant support at all times. During peak times additional staff may be allocated to the area, likewise, if additional staff are required for resuscitation of ill patients then a fast track staff member may be used. During assessment it may become apparent that the patient needs further observation or admission (we expect a small percentage of patients will need this) and they can be handed over to staff in SSU or the main department. At times when the department is very busy, we may also ask the SSU doctor to help out in fast track if they are not too busy over there.

RATT assessment

When the department is busy, and there are multiple patients waiting to be seen, a consultant or registrar will RAT patients (Rapid Assessment and Treatment). This prioritises early analgesia, time-critical treatment, and investigations. This also stops the clock for the purpose of NEAT, but the patient will still need to be picked up and seen. When a RAT assessment occurs, the doctor who has assessed will write RATT in the treatment nurse box in the PAS (if there is not already a nurse code there). They will generally then write in the management notes on the PAS what has been done/ordered for the patient, for you to check. Unfortunately, an inpatient bed cannot be requested for a patient, until they have been formally picked up by a doctor, so it's still important to see these patients in a timely fashion.

What do I do once I have assessed the patient?

In the ED the standard approach of assessment: history, examination, and investigations, followed by management: supportive care and definitive care, is modified slightly in that assessment and management may occur at the same time. For example, ordering an antiemetic for a patient with vomiting, or analgesia for a patient in severe pain is not only kind but may be essential to facilitate taking the history.

Whilst many of our nursing staff are able to insert IV cannula and frequently do, it is the responsibility of the doctor to do so. If a nurse looking after your patient is too busy, or unable to insert an IV, then you will need to do it yourself.
If you need to discuss the patient's management, then talk to the AO first. If your patient needs any blood tests, x-rays or medication, then write excellent, error free notes on the appropriate forms, correctly identifying yourself (including staff number on pathology forms) and the patient every time, and discuss with the nurse assigned to this patient.

Internal waiting room.

Once you have assessed your patient, there may be a period of time while they are waiting for results, observation, or perhaps review by another doctor. If these patients are stable, they may be sent to the internal waiting room to free up a cubicle for another patient to be seen.

What documentation is needed?

Clinical documentation

It is BHS policy that quality documentation is mandatory. Accurate, clear, detailed notes are essential in the event of follow-up, complications, re-presentation and medico-legal events. This includes documentation of your history and examination, working diagnosis, all investigations,

medications given, referrals made (including time), follow-up plan and certificates given.
Doctors are encouraged to write your list of differential diagnoses are at the end of your notes, to ensure that your plan of management makes sense.

Always write your name, your role, the date and time seen (i.e. time you initially went to see the patient, not the time of writing up the notes) in the top left corner of the medical section of the notes. Always ensure that a 'Bradma' sticker is on each page so that scanning staff can identify who the notes belong to. Your signature is mandatory. Our new chart provides prompts regarding getting clinical advice and documenting decisions that affect patient flow, and meeting the National Emergency Access Target of ED LOS < 4 hours.
Records **must** be written at the time patients are seen and **not** put aside to be written up later.
Notes are **shared** between nursing and medical staff, so please co-operate. The notes should stay in the cubicle, unless in use, or for privacy/security reasons.


EMERGENCY DEPARTMENT RECORD

18 YEARS / ADULT

Surname: ..... UR No: .....

Given Names: .....

D.O.B: ..... Sex: .....

Attendance Date: .....

USE LABEL IF AVAILABLE

Senior Review Notes Name:

Provisional / Differential Diagnosis:

Plan:

Investigation:

Treatment:

Consultation / Referral:

Disposition:

(If for admission complete ED Admission Plan MR 265.4)

Signature:

Discharge / Admission / Transfer to .....
(Please circle)

Vital signs within 1 hr of leaving department? Yes / No

Vital signs within normal parameters? Yes / No
(If no, discuss with senior MO)

Family member notified ..... (Name)

EDCC Referral Yes / No

Time of discharge: .....

Discharged by Name:

Signature:

Designation:

RISK SCREENING TOOL - Refer to EDCC if any response falls in shaded area

Do any of the following apply to the patient? YES NO

Lives alone/homeless/no fixed address/crisis accommodation?

Responsible for the care of other(s)?

Requires assistance with ADLs?

Had a fall in the last 6-12 months?

Concerns regarding drug/alcohol use?

A discharge that is "at risk" after hours (2000-0759 hrs) due to age or other circumstances

BELONGINGS / VALUABLES

Name of family member taking any items home.....

Circle any items staying with patient:

Wallet / keys / mobile / jewellery / hearing aid / glasses / dentures / money: $

Items in safe: Safe Sticker Number:

DISCHARGE

- IV removed
- Any questions from family Addressed
- Discharge letter
- Medical / Carers Certificate
- Medication script
- Factsheet Provided
- ..... (please specify)

ADMISSION

- Admitting Unit .....
- Wrist band
- ANUM notified
- Admission notes
- Medication chart
- IV order, if applicable
- ISBAR Handover to .....
  at ..... hrs
- Belongings labelled

TRANSFER

- Wrist band
- Discharge letter
- Notes photocopied
- Transport booked
  at ..... hrs
  Mode of transport .....

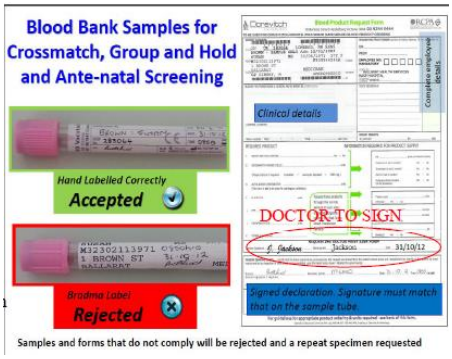
Pathology – service available 24/7

Several urgent tests can be done using the point-of-care machine including blood gases, electrolytes, and haemoglobins if needed for clinical reasons. Tests sent to the laboratory will usually take at least one hour.
Only nursing staff trained and credentialed are allowed to use the point of care tests – each of these tests requires a formal request as for any other test
It is mandatory to identify the patient correctly for each test, and it is also mandatory to correctly identify yourself for each test. This is essential to ensure that patient results return to the correct area/doctor.
Results of tests are made available via the BOSSNET system. It is the responsibility of the doctor who ordered the test to follow up the result.
All results should be FLAGGED if they are to be included in the ED discharge summary
It is EMERGENCY DEPARTMENT POLICY that all results are SIGNED OFF when reviewed. This action means that the result has been reviewed and action taken if required.

It is unacceptable to order a test and not check the results.
The ED physicians review all results that arrive after the patient has left the ED (when they would not appear on the ED BOSSNET patient list). This watchlist is easy to review when results are signed off.
A significant amount of time is wasted checking if a result has been checked and actioned with that task repeated when the ED physicians have to review the scanned clinical notes. Compliance is important to patient safety and quality assurance. This process is reviewed as a part of performance appraisals (necessary for satisfactory completion of intern ED rotation.)
DO NOT order non-routine, non-same day tests such as thyroid function or B12 levels, using ED forms and Bradmas. These are best ordered by the medical registrar or GP who is continuing the patient's care. It is very time consuming for the AO to have to follow up these results 2 days later, when they do not know the patient.
In 2012 there was a substantial increase in the cost of pathology tests and of the tests ordered, and this will be audited in an ongoing fashion. Example: ***Ordering coags instead of an INR adds cost – do you need the INR, or the entire coag profile?***

Blood Transfusion Practice

Pre-transfusion XM sample – BHS Policy



All tubes must be hand written and both the tube and the declaration on the request MUST be signed by the person who took the blood. All samples that fail to meet the policy requirements will not be accepted by Dorevitch resulting in sample recollection and delay.
Forms for consent of blood, blood products and RhD immunoglobulin must be completed. If the patient is unable to sign and the transfusion deemed necessary, the reason must be documented on the Blood Transfusion Order Form (MR/683.0)
A guide to which tubes to use for which tests is available on most IV trolleys, but there is also a copy in the Emergency Department Orientation folder on the shared S: drive, accessible via the hospital desktop.

Radiology

Hours: **Weekdays:** 0730 to 0200 hours, reception closes at 1700 hours, with only two radiographers available after that time. Radiologists are present from 0800 to 1800 hours.
Weekends and public holidays: 0900 to 2100 hours, reception closes at 1200 hours with only one radiographer after that and no radiologist in the department.
After hours: plain Xray and CT (from 1800-11.00pm)
Plain xrays are available until 2400 on weekdays, and 2100 on weekends. The AO or nurse in charge can call them back in after these times if required. A '**traffic light**

system' is available to help determine which procedures are appropriate to call in staff after hours. Basically, if an x-ray is likely to affect clinical management, or needed for admission, then it is reasonable to recall radiographers; other x-rays e.g. sore wrists and ankles can be postponed until normal hours.
After 1800 hours on weekdays, or any time when there is only one radiographer in the department, they should be contacted before sending any patient to the x-ray department. If several patients require x-rays, the request slips should be organised in order of priority and clipped to the box at the entrance to the main staff base.
After hours there is no nurse in the x-ray department. Any unstable patients should be escorted by emergency staff.

Overnight On Call Service for plain Xray and CT (after 11.00pm or 1800 on weekends)

After 11.00pm (and after 18.00pm on weekends), radiologists outsource the reading of CTs to 'Everlight'. If you need a CT interpreted overnight, you should contact Everlight directly on 1800 705 402. The same traffic light rules apply to which CTs can appropriately be ordered after hours. Please do not think that you can wait till 11.00pm and order any test you like. The radiographers will still need to come in from home, and they are entitled to a full day off work after the last call. If you call them in around 7.00am, then the radiology department lose a staff member for the day.

Liaison Radiologist

If you are unsure which Xrays to order, or want an image viewed urgently, one radiologist (or radiology registrar) will sit each day in the 'Liaison' area which is behind reception, and next to Ultrasound. These radiologists are available to answer your questions. Please talk to them, rather than interrupting the rest of the radiologists in the reporting area. They are usually available until 5-6pm on weekdays.

Imaging Reports

Monday to Friday from 0800-1700, imaging reports are dictated by the radiologists and then compiled by the typists, before they eventually are approved and appear in the BOSSNET. Xrays/scans done outside these hours may not appear in the BOSSNET until the following day, or after the weekend. These reports can be accessed on Share-point: Clinical & Clinical Support > Radiology > Radiology & Diagnostic Services Reports (Consult) tile > then enter username and password.
A version of the WEBCOMRAD app (Radiology and Diagnostics Services' Reports) is also available on the intranet (under 'Services and Departments'→'Radiology') through your smartphone (for easier listening) if you have organised approved access to hospital wifi (BASE-Data1), and can't get access to a computer with pair of headphones. Hospital WIFI access can be arranged through IT with departmental approval.

CT scans done between 1800-2300 on weekdays will be reported by the on-call radiologist (or radiology registrar) off site (who can be contacted via switch).

All CT scans done after 2300 or 1800 on weekends will be reported via Everlight (external reporting service) who can be contacted on .

CT, Ultrasound, MRI, nuclear medicine and X-Rays Requiring Contrast

- During normal hours, these studies may be organised directly with the radiographers (or nurses in radiology for patients requiring contrast), cases must be discussed with a senior ED doctor first.
- They should also be discussed with the liaison radiologist.
- Radiologists do attend at set times over the weekend, see notice in main staff base. If you need an urgent CT scan or US, out of these hours it is necessary to contact the on call radiologist to discuss the scan first, before speaking to a radiographer. Overnight CT scans will be reported by Everlight.
- Different radiographers are on call for each of CT, US, MRI and plain x-ray. They can all be contacted via the switchboard, although you should check with any radiographers in the department first as sometimes they can do it.
- Please be aware that radiographers get an eight hour break after their last call-back if called in overnight. This means that if you call them in at 7.00am, they don't have to work till 3pm but still have full pay. This is very costly for the radiology department, as well as leaving them one radiographer short for the day. If at all possible and safe for the patient, Xrays should be left till the day staff arrive.


Ballarat Health Services
RADIOLOGY DEPARTMENT
Diagnostic & Interventional Radiology, Ultrasound and C.T.
Emergency Department
Transport
Classification

Portable X-rays

Portable x-rays should be reserved for those patients too unstable to be transferred to the x-ray department (e.g. trauma patients, CXR in APO or potential arrhythmias, as well as all patients in the COVID area) as film quality is reduced and it is inconvenient for the radiographers.

X-rays in Women of Child Bearing Age

X-rays in women of childbearing age must be done with caution bearing in mind the risks of x-rays in early pregnancy. Radiographers will usually ask women if they could be pregnant, however it is the responsibility of the doctor who ordered the test to inform patients of the risks involved.

Request Forms

The brown forms are to be used for all x-rays/CTs ordered in ED other than MRI (which also needs a consent form signed), not the blue forms used in the wards (also the brown forms are not to be used for ward patients.) Electronic ordering may be available in the future. All request forms, paper or electronic, must have appropriate clinical notes to assist the radiologist with reporting. Radiologists may refuse to report Xrays if there are no clinical notes.

Pharmacy – safe prescribing

All medications to be given in ED must be written on the ED record. Prescriptions for "take home" medications can be ordered only via BOSSNET. These prescriptions can be filled at either the hospital pharmacy or any external pharmacy.

The current opening hours for the pharmacy are displayed in ED (on the doors to the after hours cupboard). Opening hours of some external pharmacies are kept in the main staff base and are generally longer than the hospital pharmacy including, one 24 hour service.

A small supply of some commonly needed medications are kept in a locked cupboard in ED, for use outside normal opening hours for the pharmacy. Please be aware that these medications are only to be used after hours in case of emergency. Most patients can be given a script for a 24 hour pharmacy. The UFS Dispensaries Pharmacy on Sturt Street is open 24 hours, 365 days a year.

Repeat prescriptions - patients often present to ED requesting prescriptions for their regular medications. If it is considered medically necessary (e.g. anti-hypertensives, insulin for a patient who is travelling and left these at home etc) then a script may be given.

We do not give repeat scripts for drugs of dependence. In all cases the patients should be advised to see their regular GP. Patients who receive regular scripts for drugs of dependence will usually be registered to one particular GP, and it is unsafe and illegal for other doctors to prescribe these. If such a patient presented with an acute painful condition however, we are able to give stat doses of analgesia, but not ongoing scripts on discharge.

Computer Documentation

Currently we have two patient information systems, both of which contain features essential to patient management. You will need to be familiar with both.

A: IBA - PAS (Patient Administration System)

The doctor must enter their own code on the computer system at the time of picking up a new patient. (Please make sure the times are accurate.) On completion of patient management, diagnosis, and if relevant, injury surveillance data, must be entered onto the system.

When the patient leaves ED, discharge details must be entered to remove the patient from the emergency system. Click on to the discharge screen, using the drop down boxes, fill in the details regarding 'Departure Status' and 'Referred to on Departure' as appropriate for your patient.

The departure date and time refers to the time that the patient actually physically leaves the department (not the time that you sit down to do your computer work). This must be accurate for funding purposes.
Do not discharge a patient before they have left the department as occasionally a patient may deteriorate before they leave and they will not be on the screen. Also the triage nurse may think the cubicle is empty and admit a new patient there, only to find your patient still present.
If any of the above data are incomplete, the patient cannot be fully discharged.

Make sure your documentation is up to date at the end of each shift. This is essential in case any patient represents, or some inquiry is made about them.

Visit History: To help you with managing your patient, please view the visit history (located via the drop-down box under 'information', on the 'clinical' screen for each patient on the 'MAP screen.) This gives important information regarding the patient's previous visits to the Emergency Department which the patient may not always divulge. Notes for any of these visits can also be viewed on BOSSNET.

Alerts: Some patients will have red (medical alert) or black (security alert) triangles next to their names. Please click on these before picking up a patient as it may have important warnings about the patient (for example, patients who are known 'sex offenders' who have behaved inappropriately in front of female staff before, or drug seeking patients that may be best seen by senior staff).

Management screen: Although not essential for funding purposes, we would also recommend that the management box in the bottom left corner of the screen is updated regularly throughout a patient's stay, so that all staff are kept informed of what is happening with your patients, including tests ordered and the results, medication or fluids given, referrals made etc.

B: BOSSNET System

Whilst times and diagnosis etc. needs to be done on the PAS system, there are also some functions that must be done on the BOSSNET system (as they are no longer available in paper form).

Checking of pathology results: All same-day results will be available on BOSSNET. You are responsible for checking all your patients pathology results whilst they are in the department.
Currently all 'non-routine' pathology tests as well as 'non-same- day' results, are added to a list of pathology results for consultant checking. Each day, one consultant will check these results, make sure that the patient had the appropriate treatment (eg correct antibiotics in UTI), and then 'sign off' the result (See section on pathology above). This is an important quality control role, but the list can be very extensive, and in busy times it

is difficult for the consultants to find time to do this. We therefore request that all HMOs 'sign off' their own pathology results once they have seen them and acted on them. If you order any plain xray after hours, or a urine microscopy on a patient, you can add the patient to your personal watch list on the BOSSNET by adding them to 'my consults', which is often helpful for your own learning, and allows you to follow up any subtle findings that may have been missed. If in doubt, discuss with a consultant.

Fracture clinic referrals. These are sent directly to fracture clinic, where their staff will triage the patient and contact them with an appointment. It is important therefore, to write accurate notes regarding the injury so that they can determine the degree of urgency.

Work certificates: These can be done on Bossnet. Currently this function can be used for ordinary work certificates for patients, carers certificates, and also WorkCover certificates, and for TAC. Paper certificates are no longer available, as these are sometimes stolen and open to manipulation by patients. This means that all patients, including staff, need to be registered via triage in order to obtain a medical certificate.

Discharge medication scripts: All scripts for medications at discharge need to be done on BOSSNET as above. Paper scripts are only to be used in case of emergency, such as when the computer system is down. One reason for this is that paper scripts could be stolen and misused.

Scanned clinical records: Once patients are discharged from ED, the handwritten notes, including nursing notes and prescriptions, are scanned within 1 to 2 days, and then the originals destroyed. If you want to look up recent visits, you can do this via the electronic record.

Discharge letters and referrals to specialists: (See below for instructions on how to do this). These are normally emailed directly to the nominated GP, using the 'Argus' system which is unique to Ballarat GPs. If a GP is not on this system, then the BOSSNET staff will fax the summary to them. If you flag results on BOSSNET then these will be added to the summary. These summaries can be used as specialist referrals, and either emailed directly via Argus, or printed off and given to the patient to take with them. If you want to use this as a specialist referral, then **add** the specialist's name to the last page where the GP's name is.

HOW to write a BOSSNET DISCHARGE SUMMARY

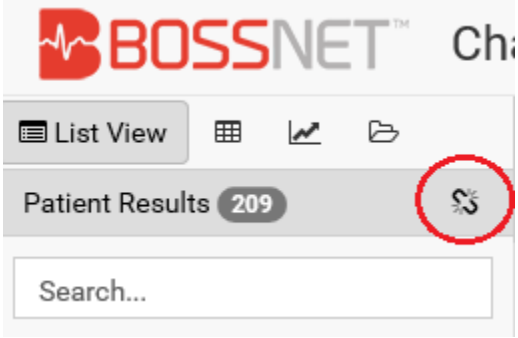
1. Make sure you have selected the correct episode for the patient (check Admission Date on History/Progress page). Best done by doing summary directly from current ED (or SSU) list.
2. Add discharge date if the patient has not already been discharged.

3. Complete required fields, those that are compulsory are shown in red. Bossnet will not let you tick 'complete' until all these fields are completed.
4. Pathology and Xray results can also be sent to the GP. Click on the results section at the top of the summary. Then click the green square with 'R" in it, at the top right corner of this page. You can then 'Flag' the results you wish the GP to see, close this section to go back to the summary, and press 'show result' to highlight the results in the summary.
5. Check the "send discharge summary to" section particularly that there is a name and that it does not have "None" next to it. (If it does have none you either need to change it or print and fax the summary). You can also add in a specialist if you are referring the patient (the system allows for multiple recipients.) Most specialists in Ballarat are on the Argus system and this will act as a referral letter, saving you time later. Also, if the patient was sent in by someone other than their usual GP, (eg. an after-hours clinic), then it is courteous to add this doctor in as well to inform them what happened.
6. You can create a draft of the document and edit it later as required, by closing with the red X in the top right corner of the discharge summary window.
7. When complete use the spell check button at the bottom!
8. If you need to print use print preview button at the bottom!
9. When finished then click Complete (only once) – this files the document in the medical record and sends it to the named recipient(s).

BOSSNET education should be provided during orientation, but simple how-to-use guides for discharge summaries, fracture clinic referrals, and Workcover/TAC certificates, and accessing the scanned medical record, are available on the intranet (under 'Services and Departments'→'BOSSNet') and in the Emergency Department Orientation folder on the S: (inside the folder 'All Users'). External hospitals in the Grampians region (eg. Ararat, Horsham, Nhill) also now use a scanned medical record (but will not be searchable via a BHS UR number), so if you need to look up their previous presentations/access their blood test results, you will need to search for them by name.

At the main staff base, there are user guides/passwords on the wall for accessing external images/reports via the PACS/inteleviewer App icon on the desktop ie. from Bendigo Radiology/Sovereign Radiology/Horsham. Lake Imaging (ie St John of God) images/reports can be accessed via the LAKE visage app on each desktop (username: bhsop1, password bhsop1)

Most external pathology results (if done by Dorevitch) are available out of hours by clicking on the paper-clip icon (community-linked results) from the 'Results Review' tab on the BOSSNET.



The after hours results hotline for Clinical Labs is 1300 134 111. For Melbourne Pathology results call 9287 7777.

Precautions:
You can create more than one summary for each episode – do not click "Complete" until finalised. Every time document is "complete" it gets sent to the GP.

My patient is waiting for results, or a trial of medication. What do I do in the meantime?
If you are waiting for results or treatment, and your patient is stable, then you can pick up a new patient. Most doctors will have multiple patients under their care at any time, but probably best not to take on too many too soon when you are just starting out.

What if I think my patient needs admission?
Discuss this with the AO first as they will have a good understanding of who needs admission and how to do it.

Authority To Admit

Generally the decision to admit is made following consultation between ED medical staff and the receiving unit. However, problems may occur if the decision to admit is made by an ED physician, and the registrars occasionally disagree with that decision. These issues are best resolved with polite communication and the registrar reviewing the patient and discussing with the ED physician and/or their consultant as appropriate.
The decision to admit a patient is often clear-cut, but occasionally difficult. Patients are admitted if believed necessary on the basis of:

1. Diagnosis e.g. AMI, #NOF etc.
2. Symptoms e.g. pain unable to be managed at home, inability to walk.
3. Co-morbidities, eg. Multiple other illnesses would reduce threshold for admission from an otherwise less serious illness.

4. Social e.g. inability to care for self.
5. Other e.g. suspicion of injury, child abuse etc.

The government is phasing in the NEAT – National Emergency Access Target with 90% of patients to be discharged or admitted within 4 hours. We believe a culture of early senior decision making is essential for patient safety and high quality care, and the same culture will be the foundation of the Emergency Department performing its role in a manner that ensures the KPI is met.

The other key elements are efficiency, teamwork, and effective communication.
Once the decision is made, the necessary steps leading to admission can be commenced e.g. informing registrars, booking beds, front sheets etc. As these steps can sometimes take hours e.g. waiting for a registrar to review a patient, it is best to make the decision to admit as early as possible and get the process started.
There will be clinically appropriate exceptions, for example:

1. Complex cases where the diagnosis is in doubt, or where several units need to assess the patient.
2. Pain being given a trial of analgesia.
3. Temporary observation e.g. trial of feeding in gastro, neuro-obs after head injury or seizure.
4. Admission does hinge on an investigation e.g. ultrasound in early pregnancy, CT in head injury.

If in doubt about the necessity of admission, ask someone senior.
If you have difficulties with registrars refusing to accept your patients you feel need admission, speak to the consultant on duty. (It is a reasonable expectation that all referrals are vetted by the ED physician on duty prior to referral).
Once you have discussed your patient with the in-patient unit, they should see the patient and assess them themselves within two hours. If there is going to be a longer delay then it may be appropriate for the patient to be sent to the ward on an 'Acute Admissions Plan' (AAP).

Who do I call if a patient needs admission?
Whenever a patient is admitted, it is essential that the inpatient registrar or consultant be informed to ensure continuity of care and transfer of responsibility. After hours this must occur at the time of admission and not be left for the following morning, especially if the patient is transferred to the ward.
Under no circumstances should a patient be sent to the ward without someone accepting responsibility for their care.

When a receiving registrar cannot be contacted immediately (e.g. they are in theatre), then a message must be left with a responsible person who will transmit the message to them e.g. the unit HMO or theatre nurse. For any urgent or time critical matter you will find that the specialists in this hospital are extremely supportive when contacted,

including for public patients when their registrar cannot answer, and they will assist with arranging someone to see the patient. The intranet switchboard page has “how to” guides to contact various departments during and after hours.

If you have difficulty with registrars not wanting to be disturbed then be re-assured that you will have the support of not only the senior ED staff, but also the consultant surgeons, paediatricians etc. This does not mean that they have to get out of bed and see every patient in the middle of the night but they must be made aware of them, to accept responsibility. If you think the patient will need review in ED by the registrar before sending to the ward, then do not be tempted to leave the phone call till 8am (you need to leave them time to see the patient before their regular morning ward round.) Once you have informed the appropriate registrar then this should be documented in the notes and the time it occurred.

There is a ROVER document (rolling handover) for ED available on the intranet and in the Emergency Department Orientation folder on the S: These are the ‘standing orders’ agreed to by the inpatient units. It contains useful information on the availability of inpatient units and the hierarchy of contacts. It also contains useful information on the limitations of the specialty services available, and basic information about emergency codes (such as calling STEMIs, strokes, trauma calls and paediatric responses).

ON CALL rosters & pager lists, phone numbers & contact details

How do I know who to call?
Always speak to an ED registrar or consultant prior to calling an inpatient registrar. After discussing the case with a senior ED doctor, speak to the relevant inpatient registrar or consultant.

Which doctor and which unit to call can be very confusing and the guidelines differ between specialties and between practices and at different times of the day.
Most registrars can be phoned directly using the *number on the roster, but HMOs usually need to be paged. The on call rosters, pager numbers and direct dial numbers are available on the hospital intranet, under the ‘clinical contact’ tab. The ‘Clinical conact’ tab also has instructions on who to contact for each specialty unit, under the ‘How to Contact (Internal) tab.

EMERGENCY	Number
BED MANAGER	Pg 4820 or *332
BOOKING OFFICE	94248
CATH LAB	96591
CONSULTING SUITE	98666
DIAGNOSTIC SERVICES	94201
OUTPATIENTS 4TH FL	94296
PATHOLOGY LAB	94365
X-RAY 94273	A/H 94295

ALFRED HOSPITAL	*003	ARARAT HOSP	*000
AUSTIN HOSP	*119	BENDIGO HOSP	*097
EYE & EAR HOSP	*175	GEELONG HOSP	*019
MERCY MATERNITY	*121	HAMILTON HOSP	*185
MONASH MEDICAL	*122	HORSHAM HOSP	*186
ROYAL CHILDREN'S	*077	MARYBOROUGH	*031
ROYAL MELB	*039	SKIPTON HOSP	*047
ROYAL WOMAN'S	*085	ST ARNAUD HOSP	*082
ST VINCENT'S HOSP	*083	STAWELL HOSP	*084
WESTERN GENERAL	*123	ST JOHN OF GOD	*015

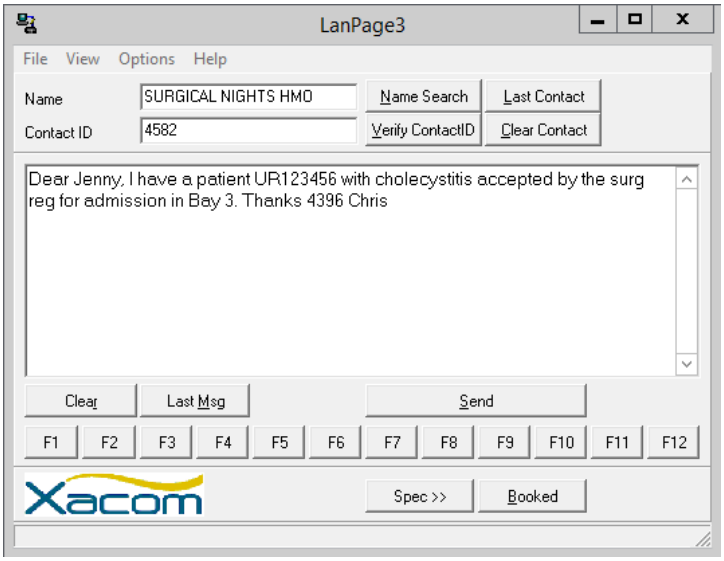
EMERGENCY	Number		
2 NORTH	94640	2 GP	94568
3 NORTH	94245	3 SOUTH	94253
4 NORTH	94958	4 SOUTH	94900
5 NORTH	94971	LABOUR WARD	94979
Special Care Nurs	94982	CCU	94511
DAYWARD	94603	ICU	94430
FAST TRACK	96894	MED DAY UNIT	96733
SHORT STAY	96921	THEATRE	94597
QEC SWITCHBOARD			93700
ADULT ACUTE UNIT			94030
PSYC SERV DAY			94123

ANAES REG O/C	*280	O & G HMO	4814
CARDIO REG O/C	*094	O & G REG O/C	*147
ENT REG O/C	*131	ORTHO REG O/C	*079
ICU REG O/C	*168	PAED RES O/N	4353
MED RES O/N	4621	PAED REG O/C	*302
MED REG ED	*150	SURG RES O/N	4582
MED REG WARD	*370	SURG REG O/C	*098

A laminated card can be obtained from switchboard when you start working in Emergency, which can be attached to your ID lanyard, and includes the most commonly used pager numbers (4XXX), hospital extensions (9XXXX) and speed dials (*XXX) for ease of rapid referral (as pictured above).

As a general rule, the medical, surgical and ortho reg have 24 hour speed dial contacts. Stable O+G referrals for admission are LAN paged to the HMO in the first instance, although expert advice which may expedite discharge from the ED can be referred to the O+G Reg via speed dial (after discussion with a consultant). Stable paediatric patients after hours (ie 2100 on weekdays, 1800 on weekends) are referred to the paeds resident via the LAN page app on the desktop). There is an admitting surgical resident overnight also available via LAN page (but all referrals must still be accepted by the Surg Reg first, unless other arrangements have been made). The speed dials for the Urology Reg on call (24h), and the oncology registrar (during business hours) are available on the intranet 'on call' lists.

If paging, make sure you put your name and contact number in the page (preferably at the start), and do not type an essay, as the messages get cut off after the first 1.5 lines.



What about Private and Repat Patients (other than TAC)
Call the consultants directly unless the patient wishes to be admitted as a public patient, then you would call the appropriate registrar. The AO will be generally familiar with specialist or unit preferences re private patients. The patient should be asked which specialist is currently looking after them, as continuity of care is important.

What happens to Overseas Patients?
A patient's nationality and/or insurance status should have no impact on their emergency care. These issues relate only to fees and costs.

Countries with reciprocal rights for Medicare i.e. UK, New Zealand and several other countries within Europe, are billed as for Australian citizens. (Please ask at reception for an up to date list of countries as the list is frequently altered and patients like to know in advance if they are going to be billed.) Patients with travel insurance may be covered, otherwise they will be expected to cover all costs (hospital bed, investigations, theatre fees and doctor's fees) themselves.

Do I need to tell anyone else about the admission?
You must tell the nurse in charge of each shift so that they can communicate with the bed manager to organise a bed. You should also tell the nurse directly responsible for care of that patient. Relatives may need to be informed if the patient wishes. For adult patients, this should be done with the patient's verbal consent, as we need to respect patient confidentiality at all times. The patient's GP will receive a fax from the hospital advising them of the admission.

Management Plan / Acute admission plans

Policy available on the intranet

What if the receiving registrar is not able to come to admit my patient?
Under the new NEAT criteria (National Emergency Access Targets), 90 % of patients need to be admitted from the ED in less than 4 hours. If the receiving registrar has accepted a patient, but is unable to come to the ED to admit the patient, and the patient is stable enough to go to the

ward, then it is possible to admit the patient using an acute admission plan. These plans are therefore an essential tool to reduce the number of 4 hour stays, as well as relieving overcrowding in the ED.

These admissions **must be approved by a consultant**, who should have seen the patient with you to make sure the admission is safe. Brief admission notes are documented on the appropriate forms, along with instructions for the nursing staff to manage the patient until such a time when the registrar is free to complete the formal admission notes and management plan. Interim orders are therefore only to be used when; the receiving unit registrar or consultant has accepted ongoing responsibility for the patient, they are unable to see the patient in ED within an acceptable time frame, a bed is available on the ward, and the patient does not meet MET criteria. Under no circumstances should a patient be sent to the ward if no-one has been notified to look after them. At all times it is preferable for the patient to be seen in the ED prior to transfer.

Acute admission plans should include the following:

1. Proposed continuing management and instructions to ward nurses, including when to call for help.
2. Medications/fluids, limited to twelve hours (usual interim period) and only essential drugs such as analgesia, antibiotics and fluids. It is essential that the registrar comes to review the patient before the 12 hours are up as they are responsible for ongoing care.

ED Handover

Formal handover will be held in the main staff base at 8.00 a.m. (Informal handover should occur any time you leave the department, e.g. for meals.) See separate policy:

The purpose of handover is to ensure that the staff taking over the responsibility of your patients are fully aware of their condition, to improve efficiency in the running of the department and to gain advice from senior doctors. The AO starting the day shift will determine the distribution of all patient handovers, to ensure a safe workload. It is ED POLICY that the doctor name is updated on the IBA system. This system represents a real time description of patient location and who is looking after them.

Every attempt should be made however, to have the patient's care organised, management plan updated on the MAP screen under management notes, referrals made and decisions made prior to shift changes.

What if I think my patient is safe to go home?
If in doubt, then speak to an ED consultant or the ED care coordinator to make sure that the patient is safe, and doesn't need any extra services in place before they leave.
Once the decision to discharge a patient is made there are a number of things that need to be done.

1. Organise discharge medication.
2. Ask the patient if they need a work certificate (see later section). If in doubt then give one anyway as patients will often return requesting one later once you have gone.

3. Discuss follow up, making sure the patient knows where, when and why to represent. (Outpatients is discussed later.)
4. Consider sending a discharge summary to the patient's GP, or in some cases phone them directly. (See below).
5. Make sure all your paper work and computer documentation is done.
6. Discharge the patient off the computer after the patient has left, making sure that the time is accurate.

ED MET Calls

We have a process in ED for escalating urgent care for unstable/deteriorating patients, particularly as they may not yet have been seen by a doctor, or their treating doctor may not be immediately available. The goal is early stabilisation and prevention of further deterioration, and the early identification of patients needing advanced resuscitation or HDU/ICU level care. Anyone can call a MET. Criteria include:

- Threatened airway (stridor/obstruction)
- Respiratory distress
- RR < 6 or > 30
- Severe hypoxia (SpO2 <90%) despite oxygenation
- P<40 or P>140
- SBP <90
- Decreased GCS by 2 points
- Seizure
- None of the above but nurse worried

These MET calls get paged overhead and the AO or an available consultant should see the patient immediately, and be involved in their management.

Emergency Codes

To call a Trauma Call, Paediatric or Obstetric response (guidelines available via the intranet), call 2222 and get senior help immediately.

All Stroke Calls between 0800-1700 on weekdays are attended by the inpatient neurology team. The AO will activate these via the PULSARA app on the AO phone and call switch. After these hours, the Med Reg will attend all stroke calls. It is important to write VST protocol on the CT request slip, and call in CT separately if after hours. The patient will be assessed and discussed with an offsite VST neurologist by videoconference. These images will not be sent to Everlight for external reporting.

Ballarat's cath lab is generally available 24-7, except in exceptional circumstances. Code STEMIs are activated via the PULSARA app after approval by the on-call interventional cardiologist. Calls are activated by the AO in the first instance, and then also by calling Switch on 94444. Once approved, the patient flow co-ordinator needs to be aware to mobilise resource and staff.

More information about these codes is available on the intranet under a Gov Doc search, and it is worthwhile familiarising yourself with these.

Other Duties

Fracture Clinic referrals

Many fractures seen in ED can be managed by the patient's GP. Those fractures requiring further management or where there is a significant risk of complications should be referred to the fracture clinic. Referrals are made on Bossnet (See above). There is a suggested list attached of injuries which are appropriate to send to the clinic and those which can be safely managed by the GP. It also has suggestions for timing of the appointment and whether they should have a repeat x-ray prior or not.

The clinic will also review some acute joint injuries e.g. post dislocated shoulders, or knee ligament injuries. It is NOT appropriate for review of chronic orthopaedic conditions e.g. back pain, or consideration for joint replacement. These should be referred to orthopaedic outpatients or back to their GP.

Discharge Letters / Letters to GPs

If you ask a patient to return to their GP for review, then you must send a discharge letter so the GP knows why the patient is there. (Often patients don't know why they have been referred!) Discharge letters are easily done on the computer using BOSSNET (see above) which gets emailed directly to the GP. Sometimes the GP is not from this area (and will therefore not be able to be emailed) so a copy of the discharge summary can be given to the patient.

Work/Sick/Carer's Certificates

All patients should be asked if they require sick certificates at the time of their first presentation. If the patient is in doubt as to the need for a certificate then it is best to do it for them any way as doing it later is always more time consuming. These can be done on Bossnet, and printed off for the patient. (See above) As mentioned above, paper certificates are no longer available, so all patients, including staff, need to be registered in order to be issued with a certificate.

All patients who present after traffic accidents or work related events should also be given certificates on discharge as many request them later (It may also be needed for billing purposes as these are technically private patients.). For TAC and Workcare, these certificates need to be done by the doctor who actually saw them. (For other, general work certificates it can legally be done by another doctor as we are stating that the patient was present at BHS, but is still best to be done by the doctor who saw the patient since they will be familiar with them.)

Workcare &TAC certificates can both be done on BOSSNET. If a patient asks for a work-care certificate, then it is best to do this. It is not our responsibility to determine if the complaint is work related or not.

If a patient who has already been discharged requests a certificate later, the enquiry should be directed to the reception staff or Administration Manager who will take the patient details, then contact the doctor who saw the patient. This involves the patient, or triage nurse, speaking to ED reception staff, with the ED Admin manager referring cases to the Director of Emergency Medicine if you are not on duty. The Director of ED includes this issue in performance appraisals given the amount of time spent on this issue by other people when it is not done in the first instance.
Carer's Certificates are often requested by relatives (eg parents or partners) of patients who need time off work to care for the patient, or drive them to and from appointments. These are done using the same certificates as above, with the patient's name at the top. Towards the bottom is a space for recording the carer's name, with a box for notes as to why they need time off.

Trauma Calls

Refer to Trauma CPGs:

- Head Injury (Closed) – Adult.
- General Approach to Trauma.
- Trauma Team Activation.
- Blood Alcohol & Drug testing In Road Trauma (more details below): Refer to Blood Alcohol Estimation in the Emergency Department CPG for a detailed description of the process. (Go to hospital intranet; Gov Doc Search; Scope by area; Emergency)

Inter-hospital Transfers

What if my patient needs to be transferred out of Ballarat?

On occasion patients need to be transferred to another facility for further care. The reasons may be:

1. Medical condition e.g. neurotrauma, paediatric multi-trauma, cardiothoracic surgery/trauma, plastic surgery etc.
2. Patient request e.g. private patients.
3. Lack of beds especially ICU.

Certain steps need to be followed to organise the transfer successfully:

- Institution and clinician you are referring to are happy with the transfer and they have an appropriate bed available. (If unable to find a bed, then call ARV on 1300 36 86 61 rather than wasting time calling multiple hospitals.)
- Patient and family are informed of the transfer and the reason.
- Paper work is completed including a copy of results.

- Some radiology (CT or MRI) can be sent to the receiving hospital via 'Hub and Spoke'. (There is a Digital Access Transfer Request form in radiology to be completed and handed to the xray radiographer. Instructions on how to 'hub and spoke' after hours are available on the intranet and in the Emergency Department Orientation folder on the S:)
- Original x-rays (or CD copy of CT scans) should also accompany the patient.
- Patient is stable to be transferred or if not, appropriate escorts are provided (via ARV).
- If a patient is to be transferred to another hospital's Emergency Department (as there are no beds in the receiving hospital or the patient is deemed too unstable, we also need to call the AO of the receiving hospital's emergency department, to advise them of their transfer.

Retrieval Requests with transfers

All retrieval requests are now handled by ARV (They can both find a bed and organise appropriate transport.) Any requests should be referred to the consultant or senior doctor on duty. The number is 1300 36 86 61.

Paediatric/Neonatal Emergency Transport Services

PIPER based at the ICU of the Royal Children's Hospital, Melbourne offers a 24 hour service for:

- Transfer of critically ill children to an appropriate bed in Melbourne.
- Telephone for advice about critically ill patients with a staff specialist in paediatric intensive care.

Phone numbers for these and other similar services are also located in the main staff base.

Education

12.1 Training program details

Who is it aimed at?

Our department is extensively involved in education at several levels. We have medical students from 2 different universities, pre-registration interns, international medical graduates (IMGs) undergoing education for AMC certification, general teaching for Interns and HMOs, Registrars in training for ACEM fellowship or the 6 month ACEM certificate, 12 month ACEM diploma and an observer program for international graduates applying for registration.

When are the education sessions?

Education is held on a Wednesday afternoon from 1.00 to 6.00 p.m. for Registrars and Thursday afternoon 2.00 p.m. to 4.45 p.m. for Junior HMOs and Interns.

What is involved?

Sessions involve formal teaching and a timetable is available for this. Medical students are welcome to attend, however some session will be restricted (i.e simulation sessions).

We have a 'buddy' program for the medical students and pre-registration interns where they are paired with an existing junior doctor and shadow this doctor to learn about the

day-to-day responsibilities of the working environment. Research has shown this to be an effective way of learning such skills. So as not to be a burden on these doctors, students are encouraged to help out with various tasks such as writing notes.
The observer program involves orientation, a multiple choice quiz, supervised clinical placement, and a self-directed work-book which involves observed mini-CEXs.

ACEM Emergency Medicine Certificate and Diploma

The ACEM certificate (EMC) is a 6 month qualification offered by ACEM, aimed at CMOs, or those wanting to enter rural general practice. It is an abbreviated form of the ACEM fellowship. There is a longer Diploma course (EMD) available for those who have completed the EMC.
Those wanting to undertake the ACEM certificate, or fellowship training, should approach either the ED Director, Project Support Officer, or the Directors of Emergency Medicine Training (DEMT).

What else is available?

- There is an 'Ap' available that outlines all education. This can be saved on the home screen of your phone or tablet: https://bhseducationseries.shareableapps.com
- There is also useful information on the ED page of the hospital website: http://educationresource.bhs.org.au/home
- You are expected to attend fire training annually, or alternatively update this via the intranet.
- BLS / ALS training should also be updated annually.
- Our department has a large number of policies and procedures which are available via the intranet if you want to learn how we do things here in Ballarat.

All staff should be familiar with the hospital Clinical escalation policy / when to call for help

If you are unhappy with advice from a senior colleague or feel that the patient will be at risk if you follow their advice, whether nursing or medical, then it is hospital policy that you should discuss the situation with someone more senior again. There are many reasons why the staff member may have misunderstood or misinterpreted a request so it should not be seen as a personal criticism. Patient safety is paramount at all times and if you feel you need another opinion then it is your responsibility to do so.

What if I need help after hours?
All ED staff, medical and nursing should be reassured that they have back up and support from consultant staff. A list of suggested situations/criteria when the Emergency Physician on call should be contacted has been compiled. This list is not compulsory, nor is it exclusive. If at any time support or assistance is required, please do not hesitate to call the on call consultant. We would prefer to know about it at the time rather than hear about it later.

The decision to call in the on call consultant is the right of both the senior medical and nursing staff.
Suggested criteria:

- Physiological e.g. reduced conscious state, patient in shock, severe respiratory distress and arrhythmias.
- Intubated patient.
- Cardiac arrest.
- Patient in resus room requiring further assistance.
- Trauma call (as per clinical practice guideline). Please remember that the ED consultants do not carry pagers and are not on the list for trauma calls and therefore will not hear about trauma calls overnight unless someone remembers to contact them directly.
- Specific emergency conditions e.g. thoracic aortic dissection, subarachnoid haemorrhage, AAA, burns, hypothermia, snake bites, toxicology etc.
- Administrative problems. Ring us: don't waste time making lots of phone calls and getting nowhere.

Miscellaneous Clinical Information

Deaths in ED – refer to BHS policies

These are handled like a death anywhere in the hospital.

- Death needs to be confirmed by a medical officer and where appropriate a death certificate completed.
- Ensure family/relatives are informed. Please try to inform relatives in person and not over the phone, especially in the case of sudden or unexpected death. If the relative is unable to come to ED, then sometimes the police or other services (e.g. chaplain), may be able to visit them at home.
- The coroner should be notified for any death occurring in the following situations:
    - Unexpected/unexplained.
    - The result of trauma, including all FALLS. (the coroner will reject the death certificate if this is written as a cause of death)
    - Under suspicious circumstances.
    - An in-patient of a psychiatric or correctional service under certification.
- If unsure if the coroner needs to be notified, then you can call the coroner's clerk and ask their advice.
- The patient's LMO should be informed of deaths of their patients because they will be involved long term in supporting relatives. The LMO may also be able to assist with death certificates in cases where the patient is unknown to you and is not a coroner's case.

Dead On Arrival (D.O.A.)

Medical staff are occasionally asked to certify death on patients who have died in the community, prior to being placed in the mortuary. Certification needs to take place in the presence of police officers. This function is usually done in the ambulance bay, but occasionally may need to be done in the mortuary.
The patient should be registered by the police/funeral directors.
Confirm that death has occurred, note date and time.
You do not need to ascertain the cause of death.
The police will record your name.

Blood Alcohol & Drug testing In Road Trauma

Refer to Blood Alcohol Estimation in the Emergency Department CPG for a detailed description of the process. This has recently (late 2015) been updated. (Go to hospital intranet; Gov Doc Search; Scope by area; Emergency)
Medical Officers in Victoria are legally obliged to test all patients over 15 years involved in road traffic accidents, even if not injured. In the past, blood was not taken if a patient had a negative breath test. The police now request that breath testing no longer be done and that **blood is drawn on all patients** to avoid missing patients who may have taken drugs. In ED this process may now be performed by a **doctor or a nurse**. It may also be done when inserting an IV cannula, provided a non-alcoholic swab is used.

- If a patient refuses testing, inform police and fill out the appropriate forms. We cannot do the test if the patient refuses, but the patient should be informed of the consequences. (Possible two years jail sentence and/or $10,000 fine.)
- Consent is not required in unconscious patients.
- We do NOT process the samples here and we do NOT get notified of the results.
- Patient's requesting results should be advised to have the "patient" sample tested at a private laboratory. There is an extra sheet at the back of the six sheets to be signed by the patient when they are given their sample.
- All patients must be recorded in the *Register and Instructions for Alcohol Testing in Road Traffic Accidents* book: including those who refuse testing.

Quality improvement activities

- Results Auditing (link to ordering)

All x-ray investigations ordered will be reported by a radiologist, and the report will be available on BOSSNET; both in the patient's individual file, as well as appearing on the consultant 'watch list'. ED consultants will check the watch list each day, read the reports, and cross check against the scanned notes to make sure the patient received the correct treatment. If not, they will contact the patient to arrange follow-up.
All pathology results will also become available on BOSSNET, however 'routine' investigations (e.g. ABGs, U&Es, FBE, LFTs) will **not** appear on the consultant watch list, as it is assumed that those who ordered the tests, followed them up at the time.

The only pathology results that are currently checked by the senior ED staff using the 'watch list' are all cultures, drug levels, d-dimers, cytology, pregnancy tests, TFTs, and ED ordered COVID tests. Like Xrays, a consultant will check the results against the electronic record to ensure the patient had the correct management. For example, 'were the bacteria found in the MSU, sensitive to the antibiotics that you gave the patient?' If not, we will contact the patient to arrange appropriate treatment.
Please note however, that medico-legally, it is the responsibility of the doctor who ordered the test to follow up the result. So please check the results at the time the patient is in the department. Also, checking the watch list is very time consuming, We would therefore ask that you 'sign off' your results on BOSSNET once you have seen and acted on them, thereby removing them from the watch list. It is much quicker for you to 'sign off' the result when you know the patient and the treatment given, than to have a consultant who doesn't know the patient have to search through the files at a later date.

Dealing with complaints

Patients are entitled to either make a complaint or give compliments regarding the care they received in the ED. Both compliments and complaints are directed to one of the consultants who will usually respond to these directly. Occasionally they may ask for your opinion as to what actually happened. This discussion should always take place in private. You should not under any circumstances have to deal with the patient directly. The vast majority of complaints relate to communication issues, waiting times or differences in expectations, rather than complaints about the care received. Compliments and complaints will both be emailed in a de-identified newsletter each month, so that we can all learn from them.

Research and audits

Our department is often involved in research activities and audits. Regular audits include hand-washing audits, as well as many spot audits for hospital accreditation. The ACEM training research requirements are fairly onerous and can be discussed with the Director of Emergency Medicine Training.

Other Services and Departments You May Be Involved With:

Ambulance Service

Ambulance officers are all highly trained and skilled in initial assessment and resuscitation of patients. Also, MICA officers possess advanced airway skills and are capable of initiating IV drugs and fluids.

Ambulance staff can usually provide useful information regarding the pre-hospital presentation and its management and patient past history, careful note should be taken of their handover and case sheet.
Ambulance control may pre-notify ED about patients; this occurs especially when resources such as resuscitation, security or trauma teams are required. These should be activated prior to arrival.
Occasionally the ambulance service may call for advice. These calls should be directed to the most senior doctor available.

Centre Against Sexual Assault (CASA) specialized services

Occasionally patients may present following sexual assault.

- If patients want to take any legal action they should be referred directly to CASA or the police. CASA will contact a Forensic Medical Officer (FMO) on call to assess the patient and take forensic evidence.
- We are not trained as FMOs and should not get involved.
- If the patient has any injuries that require immediate attention this should always take priority over collection of evidence.
- Patient's requesting medical assessment only e.g. for advice regarding prevention of sexually transmitted diseases or pregnancy and not wanting police involvement should be triaged as appropriate for their medical condition and seen as normal patients. The patients should be warned however, that what we do does not constitute a forensic examination and would not be used as evidence in court.

Psychiatry

Grampians Psychiatric Services (GPS), provide an on call service for assessment and counselling of psychiatric patients in crisis (in particular, suicide risk assessment).
The 'team' usually comprises an experienced mental health clinician who will liaise with the psychiatric registrar/consultant as necessary. Staff in GPS work in teams according to the address of the patient; a mobile number is available for triage of all referrals, they will direct your referral to the appropriate team.

It is important to assess all patients medically to identify medical causes of behavioural/psychiatric problems and to address and treat medical consequences of them e.g. toxic effects of para-suicide.

Many of the clients who attend frequently will have management plans in place. These will have been discussed with the patient and ED staff as well as psychiatric staff. Please refer to these if they exist for your patients as they may save a lot of time and frustration. These should be available on BOSSNET.

There are a number of clinical guidelines to refer to, and issues such as the duty of care and Mental Health Act can be challenging and senior ED decision making is essential. Our ED has an extremely good working relationship with our local mental health service, and they provide an excellent service to the ED and in general. Any potential disputes regarding mental health patients should result in collaboration between the senior staff from each unit.

If a patient is to be restrained/prevented from leaving, you must complete documentation regarding the reasons for this. Stickers are mandated to standardise our documentation of this.

Phone Inquiries & telephone medical advice.

Patients phoning the hospital for advice, should be directed to 'nurse-on-call'. All patients listen to specific advice on a recorded message when they ring the Emergency Department and will have ignored these instructions if they ask for advice. Occasionally, however, some of these calls will be put through to the Emergency Department. ACEM has a policy which relates to the provision of emergency medical advice over the telephone to patients who phone a hospital emergency department. Emergency departments should ensure that all emergency department staff are aware of the policy on telephone advice.

The Australasian College for Emergency Medicine believes that advice for emergency medical conditions should include first aid instruction as well as advising the caller to seek further assistance by calling an ambulance or presenting to the nearest emergency department.
In accordance with the ACEM policy, it is the policy of the BHS Emergency Department to give first aid advice only; for clinical advice, callers are to be redirected to "nurse on call".

It is not considered good practice to give advice to a patient you have not physically seen or examined. Also, we are usually too busy looking after the patients in the department to spend time on the phone.

Phone calls asking for information regarding specific patients should be directed to the treating staff, or better still, give to the patient themselves. Never give personal information over the phone unless permission is given by the patient.

Calls for the Director or Nurse Unit Manager should be forwarded to the Administration Manager on 96455. If the phone is not answered a message can be left and this will avoid the problem of missed calls.
Phone calls from GPs or other hospitals should be taken by the AO on 94801. If you answer an AO call on another phone, please transfer to 94801.

Visitors – patient centred

Visitors must be escorted from the waiting area to the patient's cubicle, even if they have been in before as patients are frequently moved and may not be in the same cubicle.
Visitor limits change frequently due to COVID rules, please check the updated rules before allowing a visitor into the department. Remember that it is the patient who is our primary responsibility and not the visitors.

For most patients, it is best to bring them into the department alone initially, to allow the staff to assess them in privacy. Children under 16, intellectually disabled patients or anybody with communication problems may be accompanied throughout their entire stay.
All these guidelines are flexible however, and it is up to the staff members to decide in individual cases what is best for their patients.

Sharps – working safely

It is the responsibility of the doctor who generated the sharps to dispose of them immediately in the correct bins. **NEVER** leave sutures/scalpel blades on suture trays for other staff to clean up after you.
All disposable non-recyclable equipment or dressings etc that have been contaminated with any bodily fluids should be disposed of in the yellow bins.
Disposable recyclable non-sharp equipment, e.g. forceps or scissors found in suture packs, should be placed in the bucket in the pan room. (These are sent to charities or overseas.)
All used non-disposable instruments e.g. vaginal speculums should rinsed and left in the pan room sink. **NEVER** leave any contaminated equipment lying around for others to pick up.
The yellow bins are **NOT** to be used for disposal of general rubbish. These bins require special handling for disposal and as such can be very expensive.

Outpatient referrals

In the majority of cases, patients should be referred back to their GP for ongoing care following discharge. If you feel that specialist review is required, then private patients may be referred directly to the specialist's rooms, and public patients may be referred to outpatients. Please be aware that places are limited, and long waiting lists, of many weeks, months or even years, exist for many clinics. If you think the patient needs to be seen more urgently than this you will need to speak directly to the registrar for approval, then document this on the referral form. Paediatric outpatient referrals will not be accepted without prior discussion with the paediatric registrar.
At this stage, only fracture clinic and allied health referrals are made via BOSSNET, but all other referrals will gradually be available on line. Once referrals are seen by the outpatient staff, they are triaged according to urgency, and they will contact the patient with an appointment time. No patient should attend outpatients without an appointment. Do not tell the patient to simply turn up. Patients arriving without

appointments generally results in lots of phone calls and unsatisfied and frustrated patients

ENT Outpatients

If you have a patient with a fractured nose, be sure to document this when requesting the appointment as the reception staff know the patient needs to be seen within a week. All other ENT referrals may have a long wait.
If there is no clinic available within the next week, it is best to contact the ENT registrar directly to arrange an early consultation.

Dental – specialised services

A dental clinic is no longer available in the hospital, it has now moved off-site to Sebastopol. This clinic is for **Health Care Card / pensioners only.** This clinic operates from Monday to Friday, 9.00 a.m. to 5.00 p.m. and does not provide an on call service. Phone number is 94225.

They may, however, be able to see urgent cases (eg dental trauma, tooth abscess) without a prior booking if during these opening times. After hours, if patients need urgent dental care, they will need to see someone privately, which will mean paying for it themselves. This cost is not covered by the hospital and this must be made clear to the patient. Refer to intranet (switchboard page) for after hour's dental care. There is a number available for an an emergency dentist during business hours on Saturday and Sunday, but this service will be associated with a cost.

Eye patients

A public ophthalmology Registrar clinic is available in BHS on Tuesday and Wednesday, via a paper referral (or calling the Ophthal Reg on the days they are here in clinic). Private patients, or those happy to incur out of pocket costs (approx $180) can be referred to the Ballarat Eye Clinic on Drummond Street (opposite the hospital) during business hours on Monday-Friday. You will need to call the clinic beforehand, and provide a discharge summary including your provider number. After hours opthal advice can be obtained from the Royal Victorian Eye and Ear Hospital ED Eye Reg, and patients with isolated sight-

threatening conditions after hours may need to occasionally be sent there for assessment, if they cannot afford to see the Eye Clinic or wait to see the public ophthalmology clinic. If in doubt, discuss with a senior ED clinician.

Toxicology Advice

The first port of call for sick toxicology patients that you are concerned about is the ED consultant or AO overnight. If requesting specialized advise on the likely ingredients of a particular commercial product to which a patient has been exposed, or an expert toxicological consult is sought by a senior ED clinician, poisons information can be contacted on 13 11 26. The centre is based at the Austin Hospital and has 24 hour access to an on-call toxicologist. We also have a copy of the Toxicology Handbook available in the main staff base, for basic management advice.

Palliative Care

All patients deemed for palliation can be referred via switchboard to the palliative care nurse on call, during business hours on Monday to Friday, who will quickly assess the patient, and may expedite their admission to Gandarra if appropriate. Actively palliated patients after these hours are usually admitted under a medical unit, or very occasionally in Short Stay if there are no single rooms available upstairs, their death is likely imminent (within 24 hours), and we have the capacity. Discuss first with one of the consultants/nurse in charge.

Plastics cases

Often simple hand injuries with no suspicion of tendon or nerve involvement can be managed by our inpatient Orthopaedic team. There is a limited Plastics service at BHS for Public patients. Referrals for this made via the orthopaedic registrar on call. Patients with private insurance during business hours may be referred to Steve Csongvay who operates out of St John of God. If an external referral to a plastics service is required, our initial hospitals to refer to are generally Geelong and Sunshine. Involve a senior for advice first.

Max-fax cases

We no longer have a maxillofacial surgeon in town. For all Max-fax cases, discuss with your senior, and referral may need to be made to a Melbourne hospital.

Other miscellaneous information

Other Orientation Resources

We have recently compiled a list of electronic resources on the shared drive (S:) which is available on every staff member's desktop. You can access the folder by clicking on the folder icon on the taskbar at the bottom of the desktop. Select "This PC" and choose the S: (the Emergency Department Orientation folder is contained within the "All Users'' folder). This folder contains both an electronic copy of this document, as well as the ED Inpatient ROVER (rolling handover) and Black/Blue/Red Team descriptions. Many other useful information is contained within this folder including all of our Emergency Department clinical guidelines (also accessible on the intranet via Gov Doc search), as well as all of our BHS emergency drug and infusion guidelines. Radiology preparation for procedures guidelines, a copy of the after hours traffic light protocol, and an after hours hub and spoke instruction guideline are also contained within this folder.

There is also a copy of the BHS HMO orientation guide (for the whole of hospital), which contains useful information on issues related to hospital maps, library, salary packaging, parking, paging system, infection control, death certificates, coronial reporting, prescribing guidelines, child protection services, and contacting our external interpreting service (for non English speaking patients if required).

ED page on the hospital intranet

Communication between all staff is difficult due to the nature of shift work, and different preferences of staff in checking messages. Our page on the intranet has lots of useful information including staff profiles, education session, and changes to practice. Please keep an eye on this as it is an important tool in our communication.

Rosters

The roster for the medical staff in ED is a complex and difficult task. (So please be nice to the person doing the roster!) The goals are to ensure adequate cover to the department while not inflicting too many socially or physiologically difficult shifts. The bottom line is the department must be staffed adequately at ALL times.

The medical roster is available on 'Roster-on" which can be accessed via the hospital intranet, or externally via visiting the website bhs.allocate-cloud.com.au/BHSProd An app version can also be downloaded to your smartphone for convenience. It is also printed each week and available next to the AO desk. Be aware that printed versions may not be up to date.

Rosters are published in advance and you are expected to be available to work all rostered shifts.

If for special reasons you are unable to work a particular day, it is your responsibility to:

- Arrange a swap with an equivalent level colleague.
- Notify the Administration Manager of the swap for approval.

It is not the responsibility of the Administration Manager to arrange a swap for you.

Swaps should only occur within the same two week pay fortnight so that they are cost neutral and should not incur overtime. This is important, to ensure adequate staffing at all times and control expenses.

Night Duty swaps are very rarely approved (only under special circumstances) and must be cost neutral. They should be discussed with the Administration Manager.

The ED Director will implement leave cover arrangements that ensure an equitable distribution of night shifts for medical staff.

We will publish a roster that aims to "not ask you to do more nights overall", and "not expect you to do less night shifts than your peers".

If unable to work a rostered shift due to sickness, phone the Administration Manager on 5320 6455. If the phone is not answered, leave a message and phone the AO on 5320 4801. If you are unable to work a shift due to being sick, please telephone as early as possible to assist with finding a replacement. On weekends you also need to call Medical Workforce On Call via switch, so they are aware early to organize a replacement if needed. Do not leave messages with nursing staff or other medical staff

as they will often forget to pass the message on due to other distractions within the department.

Any issues involving the medical roster should be directed to the Administration Manager. The medical awards are very clear on the rights and responsibilities of employee and employer in looking after staff and managing the roster.

Registrar annual leave is coordinated by the Administration Manager. Annual leave is taken in weekly blocks from Monday to Sunday to a maximum of 5 weeks per clinical year and there is no guarantee that you will be rostered off the weekend prior to annual leave. Registrars may choose to take leave in whatever combination suits i.e.; 1 + 4 weeks, 2 + 3 weeks or 5 consecutive weeks. It is expected that leave will be spread across the year including during Anaesthetic and ICU rotations.

With regards to planned leave and night shift we aim to roster night shift equitably and our general principle is that no one will avoid nights when taking leave and no one will work extra nights to cover leave. This relies on everyone's cooperation and flexibility with the roster. Where possible we apply the same principle to unexpected leave at short notice. For example if a registrar falls sick prior to or during the week of night shift then who ever covers will have their nights replaced (usually by the person who missed nights due to unexpected leave).

ED has a "first in first serve" policy when it comes to annual leave so it is in your best interests to confirm your leave requests as soon as possible.

Covering unplanned leave at short notice is very challenging and it is impossible to underestimate the gratitude we feel towards those people who give up their time to come and work at short notice. Your colleagues notice, the patients benefit, and your supervisors definitely notice your extra effort. Thanks.

SHIFT BREAKS

Everyone is allocated a 30 minute paid break during their shift, although there is often some flexibility regarding when this is taken. If you are going for a break, it's important to let your Team consultant know. There is a staff tea room with coffee and tea

facilities, and a soft-drink fridge for $2 a can. It is important to realise they are not free, and the soft drink service is maintained on a voluntary basis by a couple of nursing staff members. There are also a couple of microwaves. If you do not have your own food, BHS has a coffee shop on the ground floor Drummond Street entrance which is open till about 5pm in the evenings.

Roster-on and overtime/unplanned leave

It is your responsibility to ensure that you check roster-on, and work the allocated shifts. Any variations to Roster-on, such as overtime or sick leave, should have the appropriate forms filled in and handed in to the Administration Manager. Overtime should be approved and signed off by the rostered senior doctor. Sick leave should have a leave form completed and attached with the appropriate certificates if required. Inaccuracies on your time sheet, missing sick leave forms/certificates could result in you not being paid.

If these variations have occurred over the last weekend of the pay fortnight, then please hand them in to Administration on the Monday morning, or you may not receive the correct pay until the following fortnight..

Police statements

Occasionally you will be asked by police for a statement regarding a patient's injuries or care received in the department. This should only be done if accompanied by the appropriate paper work which includes a consent form signed by the patient for release of their medical information. You will be given a template to fill in to make this task easier. This information is then used to type up the report, which you will then need to sign.

If you are required to do a police report, a notice will be placed in your pigeon hole.

If a patient asks you for a report at the time of the visit, then explain that they need to go through the proper channels starting with the police. Any report given directly to the patient will be thrown out in court as they cannot tell if the patient has tampered with it.

Finally

Working in any Emergency department can be very rewarding at times. It can also be challenging, tiring and stressful. Our staff work as a team and aim to support each other. If at any time you feel the need to talk to someone about a problem, there are a number of options, including the Director of ED, your own supervisor, or the Medical Education Unit.

We hope that you enjoy your time working in our department!

APPENDIX A: Medical Board of Australia Guide of Intern Terms

Intern training – guidelines for terms

Clinical experience in Emergency Medicine

The Medical Board of Australia requires interns to undertake a term of at least 10 weeks providing experience in emergency medicine. This term must provide supervised experience in caring for patients who have a broad range of medical conditions, and opportunities for the intern to participate in:

• assessing and admitting patients with acute medical problems
• Managing patients with a range of medical conditions, including chronic conditions
• discharge planning or transfer, including preparing a discharge summary and other components of handover to a general practitioner, subacute facility, residential care facility, or ambulatory care.

Approved terms will provide emergency medicine must provide:

Science and scholarship – The intern as scientist and scholar

- Opportunities to consolidate, expand and apply knowledge of the aetiology, pathology, clinical features, natural history and prognosis of common and important medical presentations at all stages of life.
- Opportunities to access and use relevant treatment guidelines and protocols, and to seek and apply evidence to medical patient care

Clinical practice – The intern as practitioner

- Opportunities to assess and contribute to the care of patients with a broad range of medical conditions. This should include taking histories, performing physical and mental state examinations, developing management plans, ordering investigations, accessing clinical management resources, making referrals and monitoring progress, all under appropriate supervision.
- Clinical experience in a range of common medical conditions, including exacerbations of chronic conditions.
- Clinical experience in managing critically ill patients, both at presentation and as a result of deterioration during admission, including experience in assessing these patients and actively participating in their initial investigation and treatment.
- Opportunities to interpret investigations.
- Opportunities to observe and perform a range of procedural skills.
- Opportunities to develop knowledge and skills in safe and effective prescribing of medications, including fluids, blood and blood products.
- Opportunities to develop communication skills needed for safely delivering care through interaction with peers (particularly through handover), supervisors, patients and their families, and other health care workers involved in inpatient and ambulatory care. Interns should have opportunities to develop advanced skills in spoken, written and electronic communication.
- Opportunities to develop skills in obtaining informed consent, discussing poor outcomes and end of life of care in conjunction with experienced clinicians.

- Opportunities to develop written communication skills including: entries in paper or electronic medical records, admission notes, progress notes, discharge notes, and letters to other health care practitioners.

Health and society – The intern as a health advocate

- Opportunities to discuss allocating resources in providing medical care.
- Opportunities to participate in quality assurance, quality improvement, risk management processes, and/or incident reporting.
- Opportunities to screen patients for common diseases, provide care for common chronic diseases and discuss healthcare behaviours with patients.
- Opportunities to develop knowledge about how inpatient medical care interacts with subacute, community and ambulatory care facilities, including appropriate discharge destinations and follow-up.

Professionalism and leadership – The intern as a professional and leader

- Opportunities to develop skills in prioritising workload to maximise patient and health service outcomes.
- Opportunities to understand the roles, responsibilities and interactions of various health professionals in managing each patient, and to play an active role in the multidisciplinary health care team.
- Opportunities to further develop and reflect on skills and behaviours for safe professional and ethical practice consistent with the Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia.*

APPENDIX B: Australian Curriculum Framework

Clinical Management

Patient Assessment

Patient identification
- ☐ Follows the stages of a verification process to ensure the correct identification of a patient
- ☐ Complies with the organisation's procedures for avoiding patient misidentification
- ☐ Confirms with relevant others the correct identification of a patient

History & Examination
- ☐ Recognises how patients present with common acute and chronic problems and conditions
- ☐ Undertakes a comprehensive & focussed history
- ☐ Performs a comprehensive examination of all systems
- ☐ Elicits symptoms & signs relevant to the presenting problem or condition

Problem formulation
- ☐ Synthesises clinical information to generate a ranked problem list containing appropriate provisional diagnoses as part of the clinical reasoning process
- ☐ Discriminates between the possible differential diagnoses relevant to a patient's presenting problems or conditions
- ☐ Regularly re-evaluates the patient problem list

Investigations
- ☐ Judiciously selects, requests and is able to justify investigations in the context of particular patient presentation
- ☐ Follows up & interprets investigation results appropriately to guide patient management
- ☐ Identifies & provides relevant & succinct information when ordering investigations

Referral & consultation
- ☐ Identifies & provides relevant & succinct information
- ☐ Applies the criteria for referral or consultation relevant to a particular problem or condition
- ☐ Collaborates with other health professionals in patient assessment

Safe Patient Care

Systems
- ☐ Works in ways which acknowledge the complex interaction between the healthcare environment, doctor & patient
- ☐ Uses mechanisms that minimise error e.g. checklists, clinical pathways
- ☐ Participates in continuous quality improvement e.g. clinical audit

Risk & prevention
- ☐ Identifies the main sources of error & risk in the workplace
- ☐ which may contribute to patient & staff risk
- ☐ Explains and reports potential risks to patients and staff

Adverse events & near misses
- ☐ Describes examples of the harm caused by errors & system failures
- ☐ Documents & reports adverse events in accordance with local incident reporting systems
- ☐ Recognises & uses existing systems to manage adverse events & near misses

Public health
- ☐ Knows pathways for reporting notifiable diseases & which conditions are notifiable
- ☐ Acts in accordance with the management plan for a disease outbreak
- ☐ Identifies the key health issues and opportunities for disease and injury prevention in the community

Infection control
- ☐ Practices correct hand-washing & aseptic techniques
- ☐ Uses methods to minimise transmission of infection between patients
- ☐ Rationally prescribes antimicrobial / antiviral therapy for common conditions

Radiation safety
- ☐ Minimise the risk associated with exposure to radiological investigations or procedures to patient or self
- ☐ Rationally requests radiological investigations & procedures
- ☐ Regularly evaluates his / her ordering of radiological investigations & procedures

Medication safety
- ☐ Identifies the medications most commonly involved in prescribing and administration errors
- ☐ Prescribes, calculates and administers all medications safely mindful of their risk profile
- ☐ Routinely reports medication errors and near misses in accordance with local requirements

Acute & Emergency Care

Assessment
- ☐ Recognises the abnormal physiology and clinical manifestations of critical illness
- ☐ Recognises & effectively assesses acutely ill, deteriorating or dying patients
- ☐ Initiates resuscitation when clinically indicated whilst continuing full assessment of the patient

Prioritisation
- ☐ Applies the principles of triage & medical prioritisation
- ☐ Identifies patients requiring immediate resuscitation and when to call for help e.g. Code Blue / MET

Basic Life Support
- ☐ Implements basic airway management, ventilatory and circulatory support
- ☐ Effectively uses semi-automatic and automatic defibrillators

Advanced Life Support
- ☐ Identifies the indications for advanced airway management
- ☐ Recognises malignant arrhythmias, uses resuscitation/drug protocols and manual defibrillation
- ☐ Participates in decision-making about and debriefing after cessation of resuscitation

Acute patient transfer
- ☐ Identifies when patient transfer is required
- ☐ Identifies and manages risks prior to and during patient transfer

Patient Management

Management Options
- ☐ Identifies and is able to justify the patient management options for common problems and conditions
- ☐ Implements and evaluates a management plan relevant to the patient following discussion with a senior clinician

Inpatient Management
- ☐ Reviews the patient and their response to treatment on a regular basis

Therapeutics
- ☐ Takes account of the actions and interactions, indications, monitoring requirements, contraindications & potential adverse effects of each medication used
- ☐ Involves nurses, pharmacists and allied health professionals appropriately in medication management
- ☐ Evaluates the outcomes of medication therapy

Pain management
- ☐ Specifies and can justify the hierarchy of therapies and options for pain control
- ☐ Prescribes pain therapies to match the patient's analgesia requirements

Fluid, electrolyte & blood product management
- ☐ Identifies the indications for, & risks of, fluid & electrolyte therapy & blood products
- ☐ Recognises and manages the clinical consequences of fluid electrolyte imbalance in a patient
- ☐ Develops, implements, evaluates and maintains an individualised patient management plan for fluid, electrolyte or blood product use
- ☐ Maintains a clinically relevant patient management plan of fluid, electrolyte and blood product use

Subacute care
- ☐ Identifies patients suitable for & refers to aged care, rehabilitation or palliative care programs
- ☐ Identifies common risks in older and complex patients e.g. falls risk and cognitive decline

Ambulatory & community care
- ☐ Identifies and arranges ambulatory and community care services appropriate for each patient

Discharge planning
- ☐ Recognises when patients are ready for discharge
- ☐ Facilitates timely and effective discharge planning

End of Life Care
- ☐ Arranges appropriate support for dying patients
- ☐ Takes account of legislation regarding Enduring Power of Attorney and Advanced Care Planning

Skills & Procedures

Decision-making
- ☐ Explains the indications, contraindications & risks for common procedures
- ☐ Selects appropriate procedures with involvement of senior clinicians and the patient
- ☐ Considers personal limitations and ensures appropriate supervision

Informed consent
- ☐ Applies the principles of informed consent in day to day clinical practice
- ☐ Identifies the circumstances that require informed consent to be obtained by a more senior clinician
- ☐ Provides a full explanation of procedures to patients considering factors affecting the capacity to give informed consent such as language, age & mental state

Performance of procedures
- ☐ Ensures appropriate supervision is available
- ☐ Identifies the patient appropriately
- ☐ Prepares and positions the patient appropriately
- ☐ Recognises the indications for local, regional or general anaesthesia
- ☐ Arranges appropriate equipment
- ☐ Arranges appropriate support staff and defines their roles
- ☐ Provides appropriate analgesia and/or premedication
- ☐ Performs procedure in a safe and competent manner using aseptic technique
- ☐ Identifies and manages common complications
- ☐ Interprets results & evaluates outcomes of treatment
- ☐ Provides appropriate aftercare & arranges follow-up

Skills & Procedures

- ☐ Venepuncture
- ☐ IV cannulation
- ☐ Preparation and administration of IV medication, injections & fluids
- ☐ Arterial puncture in an adult
- ☐ Blood culture (peripheral)
- ☐ IV infusion including the prescription of fluids
- ☐ IV infusion of blood & blood products
- ☐ Injection of local anaesthetic to skin
- ☐ Subcutaneous injection
- ☐ Intramuscular injection
- ☐ Perform & interpret and ECG
- ☐ Perform & interpret peak flow
- ☐ Urethral catheterisation in adult females & males
- ☐ Airway care including bag mask ventilation with simple adjuncts such as pharyngeal airway
- ☐ NG & feeding tube insertion
- ☐ Gynaecological speculum and pelvic examination
- ☐ Surgical knots & simple suture insertion
- ☐ Corneal & other superficial foreign body removal
- ☐ Plaster cast/splint limb immobilisation

Clinical Symptoms, Problems & Conditions

Common Symptoms & Signs

- ☐ Fever
- ☐ Dehydration
- ☐ Loss of Consciousness
- ☐ Syncope
- ☐ Headache
- ☐ Toothache
- ☐ Upper airway obstruction
- ☐ Chest pain
- ☐ Breathlessness
- ☐ Cough
- ☐ Back pain
- ☐ Nausea & Vomiting
- ☐ Jaundice
- ☐ Abdominal pain
- ☐ Gastrointestinal bleeding
- ☐ Constipation
- ☐ Diarrhoea
- ☐ Dysuria / or frequent micturition
- ☐ Oliguria & anuria
- ☐ Pain & bleeding in early pregnancy
- ☐ Agitation
- ☐ Depression

Common Clinical Problems and Conditions

- ☐ Non-specific febrile illness
- ☐ Sepsis
- ☐ Shock
- ☐ Anaphylaxis
- ☐ Envenomation
- ☐ Diabetes mellitus and direct complicatior
- ☐ Thyroid disorders
- ☐ Electrolyte disturbances
- ☐ Malnutrition
- ☐ Obesity
- ☐ Red painful eye
- ☐ Cerebrovascular disorders
- ☐ Meningitis
- ☐ Seizure disorders
- ☐ Delirium
- ☐ Common skin rashes & infections
- ☐ Burns
- ☐ Fractures
- ☐ Minor Trauma
- ☐ Multiple Trauma
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Gout
- ☐ Septic arthritis
- ☐ Hypertension
- ☐ Heart failure
- ☐ Ischaemic heart disease
- ☐ Cardiac arrhythmias
- ☐ Thromboembolic disease
- ☐ Limb ischaemia

- ☐ Leg ulcers
- ☐ Oral infections
- ☐ Periodontal disease
- ☐ Asthma
- ☐ Respiratory infection
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Obstructive sleep apnoea
- ☐ Liver disease
- ☐ Acute abdomen
- ☐ Renal failure
- ☐ Pyelonephritis & UTIs
- ☐ Urinary incontinence & retention
- ☐ Menstrual disorders
- ☐ Sexually Transmitted Infections
- ☐ Anaemia
- ☐ Bruising & Bleeding
- ☐ Management of anticoagulation
- ☐ Cognitive or physical disability
- ☐ Substance abuse & dependence
- ☐ Psychosis
- ☐ Depression
- ☐ Anxiety
- ☐ Deliberate self-harm & suicidal behaviours
- ☐ Paracetamol overdose
- ☐ Benzodiazepine & opioid overdose
- ☐ Common malignancies
- ☐ Chemotherapy & radiotherapy side effects
- ☐ The sick child
- ☐ Child abuse
- ☐ Domestic violence
- ☐ Dementia
- ☐ Functional decline or impairment
- ☐ Fall, especially in the elderly
- ☐ Elder abuse
- ☐ Poisoning/overdose

Professionalism

Doctor & Society

Access to healthcare
- ☐ Identifies how physical or cognitive disability can limit patients' access to healthcare services
- ☐ Provides access to culturally appropriate healthcare
- ☐ Demonstrates and advocates a non - discriminatory patient-centred approach to care

Culture, society healthcare
- ☐ Behaves in ways which acknowledge the social, economic political factors in patient illness
- ☐ Behaves in ways which acknowledge the impact of culture, ethnicity, sexuality, disability & spirituality on health
- ☐ Identifies his/her own cultural values that may impact on his/her role as a doctor

Indigenous patients
- ☐ Behaves in ways which acknowledge the impact of history & the experience of Indigenous Australians
- ☐ Behaves in ways which acknowledge Indigenous Australians' spirituality & relationship to the land
- ☐ Behaves in ways which acknowledge the diversity of indigenous cultures, experiences & communities

Professional standards
- ☐ Complies with the legal requirements of being a doctor e.g. maintaining registration
- ☐ Adheres to professional standards
- ☐ Respects patient privacy & confidentiality

Medicine & the law
- ☐ Complies with the legal requirements in patient care e.g. Mental Health Act, death certification
- ☐ Completes appropriate medico-legal documentation
- ☐ Liaises with legal & statutory authorities, including mandatory reporting where applicable

Health promotion
- ☐ Advocates for healthy lifestyles & explains environmental lifestyle risks to health
- ☐ Uses a non-judgemental approach to patients & his/her lifestyle choices (e.g. discusses options; offers choice)
- ☐ Evaluates the positive & negative aspects of health screening and prevention when making healthcare decisions

Healthcare resources
- ☐ Identifies the potential impact of resource constraint on patient care
- ☐ Uses finite healthcare resources wisely to achieve the best outcomes
- ☐ Works in ways that acknowledge the complexities & competing demands of the healthcare system

Professional Behaviour

Professional responsibility
- ☐ Behaves in ways which acknowledge the professional responsibilities relevant to his/her health care role
- ☐ Maintains an appropriate standard of professional practice and works within personal capabilities
- ☐ Reflects on personal experiences, actions & decision-making
- ☐ Acts as a role model of professional behaviour

Time management
- ☐ Prioritises workload to maximise patient outcomes & health service function
- ☐ Demonstrates punctuality

Personal well-being
- ☐ Is aware of, & optimises personal health & well-being
- ☐ Behaves in ways to mitigate the personal health risks of medical practice e.g. fatigue, stress
- ☐ Behaves in ways which mitigate the potential risk to others from your own health status e.g. infection

Ethical practice
- ☐ Behaves in ways that acknowledge the ethical complexity of practice & follows professional & ethical codes
- ☐ Consults colleagues about ethical concerns
- ☐ Accepts responsibility for ethical decisions

Practitioner in difficulty
- ☐ Identifies the support services available
- ☐ Recognises the signs of a colleague in difficulty and responds with empathy
- ☐ Refers appropriately

Doctors as leaders
- ☐ Shows an ability to work well with & lead others
- ☐ Exhibits leadership qualities and takes leadership role when required

Professional Development
- ☐ Reflects on own skills & personal attributes in actively investigating a range of career options
- ☐ Participates in a variety of continuing education opportunities
- ☐ Accepts opportunities for increased autonomy and patient responsibility under their supervisor's direction

Teaching, Learning & Supervision

Self-directed learning
- ☐ Identifies & addresses personal learning objectives
- ☐ Establishes & uses current evidence based resources to support patient care & own learning
- ☐ Seeks opportunities to reflect on & learn from clinical practice
- ☐ Seeks & responds to feedback on learning
- ☐ Participates in research & quality improvement activities where possible

Teaching
- ☐ Plans, develops & conducts teaching sessions for peers & juniors
- ☐ Uses varied approaches to teaching small & large groups
- ☐ Incorporates teaching into clinical work
- ☐ Evaluates & responds to feedback on own teaching

Supervision, Assessment & Feedback
- ☐ Seeks out personal supervision & is responsive to feedback
- ☐ Seeks out and participates in personal feedback and assessment processes
- ☐ Provides effective supervision by using recognised techniques & skills (availability, orientation, learning opportunities, role modelling, delegation)
- ☐ Adapts level of supervision to the learner's competence & confidence
- ☐ Provides constructive, timely and specific feedback based on observation of performance
- ☐ Escalates performance issues where appropriate

Communication

Patient Interaction

Context
- ☐ Arranges an appropriate environment for communication, e.g. privacy, no interruptions & uses effective strategies to deal with busy or difficult environments
- ☐ Uses principles of good communication to ensure effective healthcare relationships
- ☐ Uses effective strategies to deal with the difficult or vulnerable patient

Respect
- ☐ Treats patients courteously & respectfully, showing awareness & sensitivity to different backgrounds
- ☐ Maintains privacy & confidentiality
- ☐ Provides clear & honest information to patients & respects their treatment choices

Providing information
- ☐ Applies the principles of good communication (e.g. verbal & non-verbal) & communicates with patients & carers in ways they understand
- ☐ Uses interpreters for non-English speaking backgrounds when appropriate
- ☐ Involves patients in discussions to ensure their participation in decisions about their care

Meetings with families or carers
- ☐ Identifies the impact of family dynamics on effective communication
- ☐ Ensures relevant family/carers are included appropriately in meetings and decision-making
- ☐ Respects the role of families in patient health care

Breaking bad news
- ☐ Recognises the manifestations of, & responses to, loss & bereavement
- ☐ Participates in breaking bad news to patients & carers
- ☐ Shows empathy & compassion

Open disclosure
- ☐ Explains & participates in implementation of the principles of open disclosure
- ☐ Ensures patients & carers are supported & cared for after an adverse event

Complaints
- ☐ Acts to minimise or prevent the factors that would otherwise lead to complaints
- ☐ Uses local protocols to respond to complaints
- ☐ Adopts behaviours such as good communication designed to prevent complaints

Managing Information

Written
- ☐ Complies with organisational policies regarding timely & accurate documentation
- ☐ Demonstrates high quality written skills e.g. writes legible, concise & informative discharge summaries
- ☐ Uses appropriate clarity, structure and content for specific correspondence e.g. referrals, investigation requests, GP letters
- ☐ Accurately documents drug prescription, calculations and administration

Electronic
- ☐ Uses electronic resources in patient care e.g. to obtain results, populate discharge summaries, access medicines information
- ☐ Complies with policies, regarding information technology privacy e.g. passwords, e-mail & internet, social media

Health Records
- ☐ Complies with legal/institutional requirements for health records
- ☐ Uses the health record to ensure continuity of care
- ☐ Provides accurate documentation for patient care

Evidence-based practice
- ☐ Applies the principles of evidence-based practice and hierarchy of evidence
- ☐ Uses best available evidence in clinical decision-making
- ☐ Critically appraises evidence and information

Handover
- ☐ Demonstrates features of clinical handover that ensure patient safety & continuity of care
- ☐ Performs effective handover in a structured format e.g. team member to team member, hospital to GP, in order to ensure patient safety & continuity of care

Working in Teams

Team structure
- ☐ Identifies & works effectively as part of the healthcare team, to ensure best patient care
- ☐ Includes the patient & carers in the team decision making process where appropriate
- ☐ Uses graded assertiveness when appropriate
- ☐ Respects the roles and responsibilities of multidisciplinary team members

Team dynamics
- ☐ Demonstrates an ability to work harmoniously within a team, & resolve conflicts when they arise
- ☐ Demonstrates flexibility & ability to adapt to change
- ☐ Identifies & adapts a variety of roles within different teams

Case Presentation
- ☐ Presents cases effectively, to senior medical staff & other health professionals

APPENDIX C: ISBAR PRACTICE CHECKLIST

A structured communication tool

Identify:

Yourself

- State your name, position & location

Receiver

- Ask to speak to the correct person

Patient details

- Name, Age, Unique ID number, Ward, Department & Bed number

Situation:

State why you are calling

- What is currently happening? If **URGENT**, say so!

Background:

Tell the story

- Admission diagnosis
- Date of admission
- Treating Unit or Consultant's name,
- Brief relevant medical history
- Summary of treatment to date

Assessment:

Your Clinical Assessment

- Vital signs
- Your clinical impressions
- What you think is going on?

Request:

State what you want from them

- Come and review the patient
- Ask for management advice
- What else should I do or prepare?

ISBAR TOOLS (2010) - Developed by Southern Health in partnership with the VMIA

APPENDIX D: BHS Emergency Department Floor Plan