SCGH ED Guidebook

SCGH ED Guide

Welcome to Charlie's ED!
Our vision is:

'TOGETHER TOWARDS A WORLD CLASS ED.'

Our core values that we expect you to adhere to are:

TEAMWORK.
INTEGRITY.
WELLBEING.

Most of the stress of starting a new job is in the daily detail rather than the medicine. That anxiety is what this guide is designed to at least partially relieve.
Please read this guide before you start work here and plan on bringing it with you to work for future consultation.
As a consultant group we bear ultimate responsibility for the clinical care to patients and as a result we expect you to follow the guidance in this book.

About SCGH ED.

ACEM – The Australasian College for Emergency Medicine was founded in 1981 by Dr Tom Hamilton, the first director of SCGH ED.
Ever since then this department has maintained very strong college links – The majority of the consultants having some role at the college – from Council Members to Examiners to committee chairs and members.
As a department education is a key priority, second only to excellence in the clinical care of our patients.
Other key interests are toxicology, litfl.com, emergency ultrasound and research and we're very keen for you all to gain experience in all of these fields

Our emergency department is a tertiary adult Emergency Department. In 2019 we saw over 73000 people with around 70% of these being triage categories 1, 2 or 3 – reflecting the high acuity and complexity of what you'll soon come to know and love as a 'Charlie's patient!'.
This works out as around 201 patients a day.
Out of these:
Around 80 of these will arrive by ambulance.
Around 50 will be admitted to an inpatient team.

- 20-25 of these will be to the MAU (Medical Assessment Unit).

Around 45 will go through our short stay ward.

Who's Who:

Medical

- Peter Allely
  - Head of Dept.
  - ACEM CAPP councillor for WA + WA faculty chair
- Tor Ercleve
  - Deputy HOD.
  - Medical Illustrator
- David Mountain
  - Immediate past HOD (x2!), Former AMA WA president
  - 50% researcher.
  - ACEM examiner.
  - Currently acting co-director on SCGH Exec
- James Winton
  - Co-Director of emergency medicine (DEMT) training.
  - Registrar recruitment and fellowship exam teaching coordinator.
  - ACEM examiner
- Jason Armstrong
  - Toxicologist
  - Director of the Poisons service.
- James Rippey
  - Lead Ultrasound consultant. DDU (Diagnostic diploma in ultrasound)
  - Fellowship exam prize winner 2002
- Jason Scop
  - ACEM Examiner
  - DDU
- Prof Tony Celenza
  - Head of UWA Division of Emergency Medicine
  - Fellowship exam prize winner 1997
- Shelley Campos
  - Works in Rockingham also where she is the Director of Clinical training.
- Lynda Vine
  - UWA Emergency Medicine liaison.
  - Violence and Security lead
- Susy Mills
  - Also works in Midland hospital where she is DEMT.
- Mike Cadogan
  - Founder of lifeinthefastlane.com, inventor of #FOAMed, Wallabies and Western force Rugby team doctor and Doctor to the stars.
  - Fellowship exam prize winner 2003
- Hakan Yaman
  - Also works with RFDS
  - Coordinates the QI team in SCGH ED
  - EM Certificate / Diploma Supervisor

- Nick Martin
    - JMO Assessments coordinator.
- Alan Gault
    - FACEM + Toxicologist.
    - Disaster Medicine lead.
- Ovi Pascu
    - FACEM + Toxicologist
- Ioana Vlad
    - FACEM + Toxicologist
    - Co-Director of Emergency Medicine Training (DEMT)
    - ACEM Examiner.
    - EM Certificate / Diploma Supervisor
    - Primary exam coordinator
- Sam Phillips
    - FACEM + DDU
    - ECMO lead.
- Richard Hay
    - FACEM + DDU
- James Wheeler
    - FACEM + DDU
    - Co-coordinates departmental CME
    - Runs scghed.com
- Ian Gawthrope
    - FACEM + DDU.
    - Coordinates Notre Dame Medical Students
    - Also works in state hyperbaric unit.
- Gayle Christie
    - Also deputy medical director of SJA.
- Lindsay Showers
    - Simulation Lead
    - Co-coordinates departmental CME
- Tom Cassidy
    - ACEM WBA lead in SCGH ED
- Gareth Wahl
    - FACEM + Toxicologist
    - Mentor Program Coordinator
- David Moore
    - Locum Consultant
    - M+M coordinator
- Candice Hanson
    - FACEM + Toxicology Fellow

Nursing

- Nicole Hoskins
    - Coordinator of Emergency Nursing
- Lydia Hele
    - Nurse Manager

- Meg Rayner + Charlotte Simmonds
    - Clinical Nursing Specialists

Admin

- Sandra O'Keefe
    - Chief administrator.
    - Departmental Matriarch!
- Bev Kingston
    - In charge of Police and legal reports
    - Has been here longer than Sandra!
- Karen Quinn
    - Manages Junior doctor rosters and departmental day sheets

Working in ED.

One of the key skills of an excellent emergency doctor is to be planning how to ***'dispose'*** of the patient from the moment you first pick them up!
You must learn how to make rapid decisions and instigate treatment plans often without knowing exactly what's going on with the patient.
You must learn that ordering more tests doesn't make you a better doctor.

You are often seeing patients on the worst day of their lives and must treat them with the sympathy and compassion you would like for yourself or your family. In all likelihood (hopefully in the distant future) you will become one of these patients at some stage in your life. ***Remember this.***
You must introduce yourself as soon as you enter a cubicle and be courteous. This can be extremely difficult when patients have cognitive impairment or drugs / alcohol on board, but you must still maintain professional courtesy in these situations.

Easy Wins:

- Be punctual. We notice when you're late for a shift and take that into account in your mid-term assessments.
- Pick a patient up as soon as you arrive - It really stands out to the duty consultant if you haven't picked a patient up 20 minutes after your arrival
- Be fussy about getting the right ***'time seen'*** in the treating doctor box on EDIS.
- Think ahead about the patients' ***disposition*** from the get go.
- RMO's and interns MUST seek out their team leader <30 mins after picking a patient up.
- Conversely team leaders must seek out juniors also.
- All beds should be booked **<< 3 hrs** after patient arrival.
- All Triage category 3's need seen within 30 minutes of arrival.
- **Never** prescribe take home opiates without D/W a Consultant.
- Timestamp your notes every time you see a patient.
- Document procedures, including code blacks.
- Identify appropriate patients for research projects.
- Don't organise swaps without the OK from ED admin.
- Be aware of how your leave requests affect your colleagues.

Dress Code.

The Emergency department is the Hospitals 'Shop Window'; as such you must strive to be a good ambassador for the hospital.
From an Infection control point of view you must be **Bare Below the Elbows** with a wedding band being the only jewellery allowed.
A lot of our patients are elderly and will have conservative views of how a doctor should dress.
A set of scrubs are supplied to every junior doctor at the beginning of your term in return for $100 deposit. We expect you to wear the tops while on shift so you can be easily identified as an ED member of staff.

Hospital policy mandates that attire should be ***'neat, clean, tidy and conservative'***:

- Conservative and reflect a professional image.
- Neat, clean, tidy, and free from external advertising.
- Footwear is to be clean, slip-resistant, and appropriate for the work environment.
- Hair should be clean and tidy.
- Head coverings worn for religious and/or cultural reasons must be secured to the side or back of the head to reduce an OSH hazard.
- Staff must be bare below the elbows.
- Lanyards and neck ties are not to be worn.
- Shoes must be close-toed and slip-resistant.
- Long hair shall be tied back and if required contained within a theatre cap and/or hairnet.

Breaks + workload expectation.

You are entitled to one 30 minute break during a normal shift.
For your own wellbeing, you must take this.
Please let your team leaders know prior to taking your break and do your best to be flexible and take your breaks when it will have the least impact on the shop floor.
If you are attending teaching you should plan on eating your meal during these sessions if practical.
Please don't leave the department during your breaks apart from to get food from an onsite café which should be brought back to the tea room or the ED junior doctor's room. This is just in case we have a major incident and need all hands on deck immediately – this is not as uncommon as you might think!

In terms of workload you are expected to pick up ***at least 1 patient per hour.***
This is monitored by the Head of department and forms a significant part of your mid-term assessments.
Multi-tasking and juggling several unsorted patients at once are key skills of any high functioning Emergency doctor. These skills are extremely useful for all branches of medicine (and life!) but you will never have the same intensity of 'Decision Density' and opportunity to learn this skill as you have in the Emergency department setting.

To learn these skills you must push yourself beyond your comfort zone. The more you do this the more you will learn. The level of senior supervision in this department makes it the ideal place to push yourself.

Teaching:

Teaching is sacred.
You must strive to be punctual.
To protect your teaching time, you must switch off your personal DECT phones (press and hold zero) during these sessions, having ensured your team leaders know what's going on with your patients prior to you going to teaching.
Teaching is nearly always in the ED Seminar room apart from Simulation training which is usually held in Trauma Bay 1.

Interns and RMO's :

Thursdays 1330-1600.
Day shift people are expected to handover their patients to their team leaders at 1315. For those of you on other shifts, your team leaders must know what needs to happen with your patients during the 2-3 hours you are away. It is not acceptable to just let your patients 'fester' while you are at teaching.

Registrars:

The main departmental CME occurs on Thursday mornings at 0800-1030.
Primary and Fellowship exam teaching occurs 1100-1300
If you are on a day shift and are not getting primary or fellowship exam teaching you are expected back on the floor at 1100.
If you are on a T shift you are expected to use the time to complete a QI project whilst in the part timer's consultant's office

Other registrar teaching:

Simulation Training:

Mondays and Fridays: 0800-0900 in Trauma bay 1.

Toxicology teaching:

Alternate Thursdays: 1600-1730. Day shift registrars should hand over their patients at 1545 and aren't expected back after teaching has finished.

Ultrasound Teaching:

Several registrars are assigned to be specifically upskilled in Ultrasound each 6 month term. Speak to the DEMTs if you're interested.

WBA's (Workplace based assessments):

We have a consultant specifically rostered onto a clinical teaching shift as often as possible, usually 2 or 3 times a week. Advanced Trainees need to be organised in advance as otherwise the only predictable WBA that can be done ad hoc will be a mini-CEX.
Shift reports should be done whenever you are a team leader – just let the duty consultant know at the start of your shift. Evening shifts will often be the easiest time to do this.
For DOPS you need to be proactive. When the opportunity arises to do a procedure just grab any available consultant to complete the assessment with you – it doesn't specifically need to be during a clinical teaching shift.

Interns and RMO's are welcome to attend Wednesday and Thursday teaching but must do so on their days off, with the exception of anyone studying for their ACEM primary exam and the Thursday morning exam teaching.

Medical Students:
We have a large number of students from UWA and Notre Dame Universities that rotate through our department. They will be allocated to a team of registrars and rotate through shifts as the registrars do.
Medical students need to work around our department. No patient should wait longer to see a doctor because a medical student is seeing them. Medical students are only allowed to see patients AFTER a senior doctor has put their names down on the patient AND introduced the student to the patient.
We had a case where a patient with syncope (and an implanted defibrillator) mistook a student for a doctor and reacting to what the student said, signed themselves out only to find out later that they'd actually had a VF arrest!
Medical student are only allowed to present cases to registrars or consultants. If they attempt to present to an intern or an RMO please point them politely in the direction of your team leader.
Medical students attached elsewhere in the hospital are not allowed in the ED without their inpatient team. Not infrequently students come down to the ED to try and get IV or stitching practice. This is unfair on our own medical students and must categorically be denied.

Sick Leave

The process for calling in sick is that ***you*** (not your mum!) must call the duty consultant ***in person*** (unless you're intubated) who will then let administration know. Sick leave is recorded in everyone's work file and forms a key part of any reference requested from the hospital.

Leave

Our administrators have the final say on whether leave will be granted or not. If they decline your leave please do not approach Consultant staff to 'fight your case' as the administrators also have to decline Consultant requests.
Any leave previously approved by central Medical administration needs to be double checked with ED admin to confirm that it will be approved.
Any new leave applications must be submitted directly to our Emergency department administrators.
It is unlikely that you will be granted leave if you are rostered on for nights for most of that week, otherwise relievers would be permanently doing nights.

Admin

Before you are allowed to start working our admin staff must have a contact mobile number and current email address.
Please respond to any requests from admin staff in a timely manner. Remember it is part of your contract to complete Police and insurance requests in a timely manner, even after you've left the department. One doctor came very close to being referred to AHPRA by the hospital for not fulfilling this duty in the not so distant past.
Swaps must be agreed in writing and submitted to ED admin for approval prior to the event. It is almost never acceptable to try and arrange a swap with someone not currently working in the ED or with a doctor of a different grade.
Our admin team need to ensure you're not breaking safe working hour restrictions. Please note your pay will always reflect what you were originally scheduled to work as any attempts to provide a more up to date roster to HCN has resulted in multiple pay disasters in the past so unless you're happy to lose money we suggest you swap shifts like for like.

Resigning Early

Please note early resignation is regarded as being unprofessional unless there are strong extenuation reasons. All early resignations result in previous referees being informed.

Mandatory Training:

There are many short online courses mandated by the department of health.
An up to date guide on to how to complete each section is available on the intranet here:

Legal

The best legal defence is to treat all patients with courtesy and respect and to practice good medicine.
Patients are much less likely to sue a doctor they liked.
A few tips:

- Make sure you document all procedures and ***sign and timestamp*** every entry into medical notes.
- You must document the names of any inpatient teams or senior Emergency Doctors you've sought advice from.
- Anyone that discharges against medical advice needs to have the capacity to make decisions assessed and documented in their medical notes along with whatever attempts you've made to persuade the patient otherwise. You also need to document whatever risks of DAMA you've explained to the patient – the more specific the better.
- **Capacity** is a huge topic but as a rough guide, we should make an attempt to establish 3 things:
    1. The patient can understand and retain the information relevant to the decision
    2. The patient believes the information.
    3. The patient can weigh that information as part of the process of decision making.
- It's mandatory to document the name of any chaperone you use when performing intimate examinations or procedures. Doctors have suffered needlessly in the past from false accusations that would have been easily defended with a named chaperone.

Seeing Patients:

Triage:

The time taken from triage to being seen by a clinician is one of the most important Key Performance Indicators (KPI) used by both the hospital and the government to judge our department.
It is also one of the most important aspects of care from the patients' perspective.
Everyone shares the responsibility to strive to meet these targets, even if it's just to 'eyeball' them to make sure they're not having a STEMI or to prescribe appropriate analgesia for a ? Renal colic patient. This should be a key part of your 'learning how to multi-task' strategy.
The national targets are below. Historically triage category 3's are the ones we struggle the most to meet (although our performance is still among the best in the country!). Effective team leaders will make sure almost all category 3's are seen within 30 minutes to ensure efficient patient flow through our system.

AUSTRALASIAN TRIAGE SCALE CATEGORY	TREATMENT ACUITY (Maximum waiting time for medical assessment and treatment)	PERFORMANCE INDICATOR THRESHOLD
ATS 1	Immediate	100%
ATS 2	10 minutes	80%
ATS 3	30 minutes	75%
ATS 4	60 minutes	70%
ATS 5	120 minutes	70%

In an effort to try and improve our waiting times we have introduced a 'Rapid Assessment and Treatment' consultant who is based immediately behind triage 1000-2400 Monday to Friday. Their focus is on early senior decision making and initiation of appropriate investigations and treatment for category 3's and 4's. They will make comments in the EDIS clinical comments box or in the patient's notes. If you can't see what they've done give them a ring.

WEAT:

The WA Emergency Access Targets (previously known as NEAT) is our second major KPI. WEAT has radically changed the way we work in SCGH ED – largely for the better.
Prior to its introduction up to 70% of our cubicles were taken up with patients awaiting an inpatient bed. We literally had patients die in the waiting room because there was no space to put them in the main department.

The target is that 90% of all patients attending our ED must be admitted to a ward or discharged within 4 hours of their arrival.
Amongst the factors we can control, good communication and ***early senior decision*** making are the key elements to good patient flow in the ED. Team based care was introduced to facilitate these.

Team Based Care:

At triage every non-fast track patient is alternately assigned to either blue or green team.
At the start of your shift you should check the ED day sheet to see where you have been allocated. Unless specified by a consultant you are not allowed to be involved in the care of another team. Every team has a consultant or registrar assigned as the team leader.
As a team member you must take from the top of the EDIS list i.e. the next patient assigned to your team who hasn't been allocated a treating doctor already. If they have a named senior doctor already you must still pick them up and become the treating doctor unless directed otherwise by your team leader or the duty consultant.
The RAT consultant should be putting their thoughts on a plan and likely disposition in the clinical comments on EDIS. Feel free to ring them for further clarification if necessary.
All patients seen by the RAT must also be discussed with your team leader.

Once you've sought advice from your team leader or duty consultant please DO NOT DOCTOR SHOP if you don't like their advice. You need to politely explain to the senior doctor what your concerns are and seek clarification. If you have ongoing concerns speak to the duty consultant directly.

Roles and responsibilities:

- **Team Members:**
  - See multiple patients concurrently.
  - All Interns and RMO's must have a senior doctor's name beside ALL their patients on EDIS.
  - If a patient has been seen first by a senior doctor, give them a call to see what their thoughts were and act on them.
  - Present all patients to your team leader with your plan ***within 30 minutes*** of picking them up.
  - Ensure all inpatient beds are booked ASAP **<< 3 hours** after patient arrival.
  - You **MUST** attempt to contact the inpatient team when booking a bed.
  - Minimise tests and x-rays.
  - Complete boxes on EDIS as you go.
  - You must not leave the department until all EDIS boxes are done and results are acknowledged.
  - Attend team codes immediately.

- **Team Leaders**
  - Be a positive role model and carry a patient load.
  - Concentrate on ensuring all triage categories 2's and 3's are seen within target times. Don't be afraid to allocate patients to team members before they ***feel*** ready.
  - Ensure all inpatient beds are booked **<< 3 hours** after patient arrival.
  - Ensure all patients on their team leave the department < 4 hours.
  - Ensure Obs patients are reassessed and discharged in a timely fashion.
  - Ensure all doctors on their team are carrying an adequate patient load.
  - Provide advice and troubleshoot admission decision difficulties.
  - Strive to ensure all junior doctors approach them within 30 minutes of picking patients up.
  - Respond immediately to any codes that come in under your team and manage your teams resources efficiently by de-escalating your team members ASAP

- **Duty Consultant**
  - Be a positive role model for the entire department.
  - Carry a patient load as possible.
  - Maximise usage of Obs.
  - Police bed booking times.
  - Carry DECT phone 77255 to receive calls from:
    - Non-ED staff who request to speak to doctor.
      - Re: incoming patients.
        - Accept, decline and redirect as appropriate.
        - Ensure Hospital admission policy is adhered to.
        - Maintain and update the expects list on EDIS
      - Provide medical advice to external clinical staff.
    - RFDS and SJA RE: incoming patients
    - Pathology + Radiology re: abnormal results
    - Triage
      - Advice on complex triage decisions.
    - Switchboard re: codes
    - Hospital Public relations team.
  - Ensure all Category 1 and 2 patients are seen in timely fashion.
  - Ensure all Code Blacks, Trauma and Stroke calls are dealt with immediately.
  - Provide backup advice if team leaders unavailable or unsure.
  - Provide ultimate authority for inpatient admission destinations.
  - Provide assistance to Nursing in identifying who is safe to be de-monitored and leave the resuscitation area
  - Monitor Ambulance distribution and feedback to hospital exec if grossly outside agreed distribution ratios.
  - Supervise any handovers between non-consultant team leaders.
  - Take incoming sick calls from medical staff and adjust teams accordingly.
  - Ensure workload is equitable across teams and fast track and redistribute staff as appropriate.
- **RAT Consultant**
  - 0800-1000 acknowledge and action radiology and microbiology results.
  - 1000-0000 based at triage unless we have good flow INTO the main department.
    - Screen as many triage cat 3, 4 +5's as possible.
    - Click on time seen and senior doctor box.
    - Prescribe analgesia and fluids.
    - Complete blood and radiology forms and order CT's.
    - Contact inpatient teams and book beds ASAP, especially MAU.
    - Document brief plan in notes or in clinical comments on EDIS with name and time stamp.
- **Fast Track**
  - Expedite fast track patients from the waiting room.
  - Please note doctors are expected to fetch patients from the waiting room also.
  - Ensure all fast track patients leave the department within 4 hours.
  - Report to Duty Consultant if fast track not busy.

- **Obs Intern**
  - Prior to the morning ward round starting the Obs intern ***must liaise with the nursing Obs coordinator*** to identify:
    - Likely quick discharges
    - Patients suitable for transfer to the discharge ward
  - These patients should then be prioritised on the obs ward after any critically ill patients have been seen. This helps free up space for incoming patients.
  - Attend ward round with Obs registrar and Consultant.
  - Complete tasks from Ward round.
  - Ensure all Obs patients have a brief discharge letter completed on Communik8.
  - Present to Duty Consultant if all Obs tasks completed for redeployment.

- **Obs Registrars**
  - Patients who obviously require overnight admission should be immediately handed over to the Observation (or Toxicology) registrar.
  - The Obs registrar becomes the treating doctor at the end of the admitting doctors shift.
  - The Obs registrar should actively seek out and pull Obs type patients from the main department.
  - The Obs registrar should strive to make even a rudimentary line in the medical notes of all patients (even those for whom they're not the treating Dr) in the Obs ward to maximise coding.
  - The RAT can continue to admit patients directly into the observation ward from the waiting room and expect the Obs registrar to 'see and sort' but they should ensure a very brief (1 paragraph) impression, plan, initial analgesia and fluids are documented. The Obs reg is empowered to call the RAT consultant and remind them to come and document accordingly.
  - The duty consultant should be sensitive to the workload of the Obs registrar and may have to reassign other staff to assist should the need arise.
  - Transfer of patients to the observation ward should not be delayed by medical handover.
  - The Obs registrar does not attend teaching on Thursdays (exam teaching excepted)
  - The night Duty Registrar should seek out the Obs Reg at 2300 and should proceed to obtain handover from the evening Obs registrar.
  - On Saturdays and Sundays, the outgoing day Obs reg should handover to whichever registrar is not team leading.

- **<u>Overnight Registrars</u>**
    - Mandatory Notifications for the on call consultant:
        - All intubations – unless previously discussed with on call consultant
        - All Major Traumas.
        - All Major Incidents
        - Any inpatient team misbehaviour.

Paperwork + Documentation:

All notes must be **signed** and **time stamped**.
For RMOs and interns it is mandatory to document which senior doctor you've discussed the patient with.
Any subsequent reviews must also be documented and time stamped. This particularly applies to all patients admitted to Obs and all patients having procedures performed e.g. Lumbar punctures, Central Lines, Dislocation and Fracture reductions.
The only time you shouldn't use the ED notes is with a trauma patient – instead you should use the ***trauma sheet*** which can be found in either of the trauma bays.
Once you've completed your notes and done your 'EDIS boxes' simply leave the notes with the clerks at the end of the flight deck and they'll process things further before taking them off EDIS.
Never take patients off EDIS yourself – apparently this is standard practice in other Perth Metro hospitals. ***It is NOT permitted in SCGH.***
You must get good at writing notes as you go. Notes written at a later date (even at the end of a shift) are inferior compared to notes written contemporaneously.
Writing good emergency department notes is an art in itself. You need to be a bit like Goldilocks in that you write just enough - not too much and not too little.
You must not write copious notes to the level of an inpatient clerk in for every patient – if you're consistently using more than the 2 sides of the proforma you're probably not in the Goldilocks zone and are wasting valuable time writing.
In the new era of activity based funding for hospitals, the quality of your notes will eventually actually pay for next year's doctors salaries!
For Obs and Tox admissions, make sure you document patient complexity in particular. Easy wins for the department are:

- Drug / Alcohol ***dependence*** not intoxication.
- Specify any electrolyte disturbance.
- ***Ureteric calculi*** NOT Renal Colic!
- Malnutrition.
- Pressure Ulcers.
- Diabetes **AND** listing complications

IT Programs:

Unfortunately you will need to become familiar with multiple computer programs to be able to care for your patients appropriately. All of these are best learned from actually using them but a brief overview of hints and tips will hopefully let you see which bits we think are the most important.

EDIS

This is the tracking program used by most Emergency departments in Perth metropolitan area. Keeping it up to date is a key clinical governance issue. It is not acceptable to be '***too busy'*** to keep up to date with your patients on EDIS.
The most important habit to get into is clicking the '**time seen'** box ***before*** then putting your name in the treating doctor box.

A few useful tips:

- **'Doing Your Boxes'** means ensuring the following 4 boxes have been completed:
    - Primary Diagnosis
    - Consultations
    - Investigations
    - Procedures

  This needs done as the clerks can't process the patients any further until the doctors have their boxes leading to the appearance of people staying longer than 4 hours when they haven't.
- **NEVER USE THE HANDOVER BUTTON!**
    - It's broken and completely distorts all our statistics.
- **NEVER REMOVE PATIENTS FROM EDIS.**
    - Other hospitals rely on the doctors taking patients of EDIS.
    - In SCGH ED ***ONLY*** the clerks are allowed to do this.
- The clinical comments box is a legal extension of the medical notes – use it wisely. In the past we've had an RMO try to chat up another RMO via the medium of clinical comments!
- **Undo an entry:** If you've entered the wrong time or doctor's name into EDIS you can remove it by holding CTRL and clicking the box again.
- **Consultations** – Please try and click on this box in real time (or back date accordingly) as much as possible as inpatient teams are audited on their response times by executive and we need to have as much data integrity as possible for the results to mean anything.

ICM – Clinical Manager.

- Found in the START menu under HEALTH.
- A great way to access My Health Record – in the app links tab
- Most commonly used for results checking and acknowledging.
- Also contains recent discharge letters from Metropolitan Hospitals.
    - Can be essential reading in code situations
- Can be customised to create your own lists – especially useful for interns seeking to create a list of unacknowledged results from the previous 7 days.
- Nervous your bloods have got lost? – check the orders tab for reassurance.

Electronic Bed Management.

- Getting inpatient beds booked in less than 3 hours is one of our hospitals KPI's for this Emergency department.
- Beds should be booked just prior to contacting inpatient teams to politely inform them of our decision to admit.
- If the inpatient team are uncontactable, document in clinical comments, click on the consultations box on EDIS that you've tried and try again a few minutes later.
- **It is never acceptable to send patients to the wards without successfully letting the inpatient team know.**
- The electronic bed management intranet site is bookmarked on most computers' internet explorer but can also usually be found with autotext by typing bed management in the address bar and clicking on the link that appears.
- There are 4 **mandatory** boxes to complete.
    - Specialty
    - Admitting consultant
        - Best found by checking the 'Daily Roster' intranet page and using CTRL C then CTRL V to copy and paste.
    - Diagnosis
    - Past Medical History
- Please note you should never complete any information in the past medical history. It is not a clinical handover tool and you are wasting your time. As a department we insist you simply put x in the mandatory field.
- The only other box you should ever complete is in the notes section when you are admitting someone under emergency – you will need to clarify whether they are an Obs or an EDU admission.
- **Quirks**
    - **MAU**.
        - MAU is 'General Medicine 7'
        - All MAU admissions are made under Dr Kamdar (General Medicine HOD)
    - **General Surgery.**
        - SAU is 'Surgical Acute Unit'
        - Beware the Gen Surg consultant on take often changes at 6pm.
    - **Oncology.**

        - Oncology patients are admitted under the oncologist that knows them best, not the oncall person – the patient will usually be able to tell you who this doctor is.
    - **ICU** patients ***must*** be admitted under an inpatient team and that team must also be made aware of their admission. All ICU patients need medical escort to ICU by a doctor capable of troubleshooting any ventilator issues e.g. usually a Registrar or Consultant.

e-Referrals:

- Most commonly used for orthopaedic and plastic surgery reviews.
- Keep the referral note brief and to the point following the specialty specific guide on the side.
- Please note – GPs actually prefer to make the outpatient referral themselves (as then they definitely get included in any communications) so unless the patient needs reviewed in a few days please send them back to their GPs
- If you make an e-referral on a patient you must document so at the end of your ED proforma so that the clerks can ensure the notes reach the clinics in a timely fashion.

Communik8:

This is a WA Health designed program that pulls all the information entered into EDIS and creates an automatic discharge letter that gets faxed to their nominated GP around 3 hours after they've left the ED.
In the vast majority of patients the automatically generated letter is adequate however in patients where GP follow up is essential please give the patient or carer a physical copy of their discharge letter to serve as a focus for them to see their GP ASAP (and as a back-up in case their fax machine is broken).
All patients referred in from another care facility should be given a hard copy of their communik8 letter to go home with regardless of the quality of notes they were referred in with.
Keep the communik8 letter brief and to the point and specify why you want the patient to see their GP
e.g. 'Please consider arranging upper GI endoscopy through the private system'
Be polite – the phrase ***'Please Consider'*** allows the GP appropriate wiggle room to decline our suggestion if they feel it is unwarranted – a position we must respect as they often know the patient and their situation much better than we do.

Ordering Tests:

IV Access:

Does your patient ***really*** need a cannula? Around 50% of the cannulae we place in the ED ***never*** get used on the wards.
You must use the IV packs and sterile gloves while maintaining a sterile field to place any IV cannula in our department. The days of using an alcohol wipe are gone and nursing staff are rightly very intolerant of any doctors who think otherwise.
It is **YOUR** responsibility to dispose of your sharps and tidy up your mess afterwards. Offenders are very quickly fed back to the head of department and we have a very low threshold for recalcitrant offenders to face formal disciplinary action.
Each year about 2 patients die in SCGH because of sepsis related to peripheral lines. You are encouraged to learn how to use ultrasound to help with your vascular access but only under the supervision of one of our DDU consultants.

Ordering Blood tests:

This is a key area where you can minimise testing and maximise your efficiencies. Very often the only blood needed may be a venous blood gas – it gives you haemoglobin, electrolytes and creatinine amongst many other things.
Please don't duplicate unnecessarily – do you really need to send a U+E if you've got a VBG? Do you really need to do any blood tests on a young patient with simple pyelonephritis or gastroenteritis? Discuss with a senior doctor – we will generally be very impressed if you ask 'Is it OK not to do any bloods in this patient?'
Only registrars, Consultants and senior nurses have access codes to the blood gas machines.
Blood gas usage is monitored and any outlying users have their access revoked.

Blood cultures are regarded as a standard of care for inpatients with fevers. The complete opposite is true in the ED where they've been shown to change management in < 1% of cases and create a whole lot more troublesome false positives.
Generally they should only be sent in the critically unwell, returned travellers and the immunocompromised (– e.g. Chemotherapy, steroids, alcoholics)
Don't send off 'screening' MSSU's unless you really suspect the patient has a UTI. If you are discharging someone with a UTI on antibiotics you ***must*** document which antibiotic in the clinical comments section of EDIS. The consultant doing microbiology results acknowledgement in 2 days' time will be disproportionately impressed.

All blood grouping and cross matching must have ***matching*** signature date and time stamp on both the bottle and the form otherwise the lab will stick it in the bin.

Radiology:

Again you should minimise your testing. Contrary to popular practice plain abdominal films are generally useless unless you suspect perforation, obstruction or a foreign body. Constipation is a clinical diagnosis, not a radiological diagnosis. You should X-ray your own colon first as a control!
X-rays can be viewed on most PC's and we have 2 dedicated PACS viewers on the flight deck. You can listen to dictated reports prior to them being typed up by logging in to mediweb.

Plain Films:

X-ray forms should be walked round to X-ray reception during hours or left in the box opposite cubicle 15 out of hours.
Any X-rays ordered on patients in the transfer lobby beside triage should be given to the HSAs to deliver to Xray
Patients in Resus generally get portable films – leave the form with the patient and page the radiographer on 4222 with the message 0001 with the final number being the cubicle the patient is in and they will come and do it ASAP.
Please remember portable films are significantly inferior to departmental films so you should endeavour to de-monitor as many patients as possible to preferentially get a departmental film. We have an overly conservative culture of monitoring everything in this department with a vanishingly small pick-up rate of unexpected events. You should be very proactive in letting the Resus nurses know a patient can be de-monitored.

CT Scans:

The following CTs can be requested without speaking to a radiologist:

- Non contrast head and cervical spine CTs.
- CTPAs – as long as the completed PE pathway is attached to it.
- CT extremity if requested by an Ortho reg (their name documented on form)

Simply take a request form to the radiology reception desk or the CT scanner.

All other CT scans must be discussed with a radiology registrar - best reached by phoning 73996 during hours and 76815 out of hours.
Once discussed, leave the form at the X-ray reception during hours or with the CT technicians in the CT room out of hours. Our radiology registrars and CT technicians work a full shift pattern which should minimise delays to scanning but please don't abuse this service with CT's that don't necessarily need done overnight. Many scans can very reasonably wait until the next morning.

Ultrasound Scans:

The large majority of scans are performed by our own DDU qualified consultants. On shifts when they are not available all ultrasounds must be discussed with a radiologist who will advise where to send the request form – usually to chute 25.
Our Ultrasound Consultants are especially keen to see undifferentiated shock / SOB / septic patients – we've picked up many unexpectedly obstructed kidneys, necrotic gallbladders and pericardial effusions over the years to name but a few.

Nuclear Medicine:
V/Q scans make up the large majority of the use of our nuclear medicine colleagues. All requests must be discussed with the oncall nuclear physician and be accompanied by a completed PE pathway and green nuclear medicine request form.
V/Q services are usually offered up until around 11pm. If it won't affect their disposition it is often not unreasonable to defer the scan till the morning.

MRI:
Most MRI requests from the ED are in reference to excluding cauda equina emergently. All request forms need signed by an ED consultant and they must have the obligatory MRI questionnaire boxes checked.
For non-emergent MRIs it's interesting to note that most if not all private radiology firms in the state will accept SCGH request forms for MRI's as long as it's signed by a consultant with a clearly readable provider number. Some even bulk bill - meaning they will be done at no cost to the patient.

Codes:

During your shift you will come across several codes being announced over the department speakers. They are usually announced by the triage nurse and will specify which team is required e.g. 'Red code team to Resus'.
Occasionally a code will need to be called by a doctor in the main department – this is done by dialling '55' and then specifying which code to Switchboard. Emergency Procedure codes can be found on the back of your ID badge but we have several Emergency department specific codes you need to know about as well.
You ***must*** stop what you're doing when this happens and immediately report to Resus. Your team leader will often de-escalate you very quickly and let you get back to what you were doing but attendance is mandatory.
We get around 3 category 1 patients a day, or at least 1 per shift.
There are other ***specific*** codes that aren't always triage category 1's that still require immediate attendance:

- **Trauma Codes:**

There are 2 levels of trauma team activation:

1. **ED Trauma** – Notification only pages to general surgery, anaesthetics and radiography
2. **MAJOR Trauma** – Mandatory attendance pagers to general surgery, anaesthetics and radiography.

Between Midnight and 0800 the duty consultant will also get called on their mobile with all major trauma codes.
Please note neurosurgery and orthopaedics are not included in the page.

- **Stroke Calls:**

We are now the state stroke centre and offer 24/7 thrombolysis and clot retrieval for everyone north of the river. Fiona Stanley hospital provides a thrombolysis service 24/7 and performs clot retrieval during working hours - 0800-1600 Mon-Fri. Royal Perth and Midland are currently the only other hospitals in the state that offer a thrombolysis service.
Patients are usually identified prehospital by SJA and phoned through to 'the Batphone'. The pathway for prehospital code stroke activation is posted beside the Batphone and is quite complex. Advice to SJA should only be given by a registrar or consultant.
Our job in the ED is to look for stroke mimics and reversible causes, risk stratify with a view to potential reperfusion therapy and to expedite imaging.
You will still need to discuss the case with radiology.
During hours the Consultant neurologist is very often present within minutes to help with these complex decisions. Out of hours, if you make a stroke call you will then be put through to the neurology registrar's mobile phone to provide a bit more history.

- **Code Blacks:**

Unfortunately these are very common. We average about 3 a day. These are not announced over the speakers and are usually coordinated by the Duty consultant but if you are the treating doctor you will be expected to help out. The best outcome in these situations is verbal de-escalation but this often fails leading to a significant number of people requiring sedation and even restraints being applied.
The safety of our staff is paramount and assaults on staff are not infrequent so we advocate erring on the side of caution if you're unsure whether to sedate or not. Senior advice is always available.

- **Code STEMI:**

There are strict criteria for calling a code STEMI. Please refer to the flowchart in the guidelines section of scghed.com.
Only the most senior doctor in the department can call a code STEMI and the pathway encourages a low threshold for discussion with the cardiology consultant on call (**NOT** the registrar) if a patient is borderline.
Once you've activated a code STEMI you must go to the Cath lab ***immediately*** during hours. After hours you must go to the Cath lab exactly ***10 minutes*** after activation and wait outside the lab for everyone else to arrive. The only caveat is if they are unstable e.g.: Pulmonary oedema or recurrent VT which should again be discussed directly with the Cardiology consultant.

Pre-hospital Activation: All ambulances in metropolitan Perth are now fitted with 12 lead ECG monitors that can transmit to our fax machine. Once they send an ECG they will ring our Ambulance Priority phone. Their pre-hospital activation protocol is meant to exclude any borderline patients but you must still double check the patient's history and background.
If you're satisfied the ECG is diagnostic, activate a code STEMI by dialling 55.
Ideally the patient is to go straight to the Cath lab without entering the emergency department. However, if it is out of hours and the ambulance is less than 10 minutes away the arrangement is that the patient waits in the emergency department on the ambulance trolley until 10 minutes after activation has passed before then proceeding immediately to the Cath lab.
Please note if the pre-hospital patient does not meet code STEMI criteria you must instruct the ambulance to go to their originally scheduled hospital (which may not be SCGH)

- **Code Sepis:**

This code has been developed to promote the early identification and treatment of patients with sepsis.

Disposition:

There are several disposition possibilities for our patients:

1. Home. (or normal abode e.g. Nursing home / Prison)
2. Admitted to inpatient team.
3. Admitted to Obs or Toxicology.
4. Transfer to another hospital.
5. Death in the department (around 2 patients a week).

Discharging Patients:

Despite the complexity of our patients we do successfully discharge the majority of patients from the ED.
We have many services in place to help you discharge some patients that traditionally would have been admitted. In general any patient referred in from a nursing home should be discharged back there unless the patient requires some level of care that they can't provide e.g. a patient with pneumonia requiring Oxygen.
For some nursing home patients you need to ask yourself
'Will any of these tests affect the patient's management or disposition?'
If not, it's probably an unnecessary test.
E.g. would this bed bound patient with dementia be a candidate for neurosurgery if they are found to have a subdural on CT? Would they warrant any change in medications if they were found to have a raised troponin?
These decisions are complex and will need to involve conversations with the next of kin and your team leader and / or consultants.

- **Discharge Ward:**

This is a fully equipped and staffed ward on Watling Street that is open 0800-1700 Monday to Fridays. It is an excellent place to send patients who are waiting for transport to home, care facility or a private hospital. They cannot take anyone requiring cardiac monitoring. The Obs team should strive to maximise the number of patients discharged through there so we can free up beds in Obs first thing in the morning.

- **Discharge Coordinators + Private Hospitals:**

We have 2 highly experienced discharge coordinators who are available 0700-1530 seven days a week on extension 7**2086**. They are experts in facilitating transfers back to care facilities, private hospitals, and arranging Silver Chain and Hospital in the Home. They will sort out the appropriate level of documentation required to go with the patient and will arrange appropriate patient transport.
Out of hours it is the responsibility of the doctors to arrange private hospital transfers. In general it is most commonly arranged for cardiology patients with the patients' preference being paramount.
It is courteous to offer any new private patients to the SCGH consultant on call first. Of note, the patient will usually have to pay the bill of an ambulance transfer to a private hospital which can be >$600. This should be made clear to them (and the discussion documented) prior to beginning to arrange their transfer. Holywood hospital has recently agreed to cover this cost **ONLY** for cardiology patients.

The first step in arranging a private transfer is to contact the chosen hospitals bed manager who will confirm if a bed is available and then offer advice as to the process beyond that.

- **Silver Chain**

Silver Chain provides the easiest referral mechanism for several conditions that should usually be managed in the community that present to the ED, such as:

  - IV antibiotics – usually cellulitis
  - Constipation – this should rarely if ever be managed as an inpatient.
  - IV fluids.
  - Wound care follow-up.
  - Anticoagulation

Referrals can be made by phoning 08 9242 0347 which puts you through directly to one of their nurses who will instruct what needs to be done from our side of things.

- **Pharmacy:**

A pharmacist is available during office hours. To be honest the doctors don't have much interaction with them apart from in circumstances when they're prescribing drugs off label or in special circumstances.
Please note, patients don't get given free drugs to go home with from the GP and the same principles should generally apply from the ED.
If someone's going home at night they can be given the first dose in the ED with the expectation that they file their prescriptions the next day.
There are multiple late night pharmacies in Perth eg: Amcal on the Stirling Highway in Claremont is open to Midnight and there is a 24 hour pharmacy on Beaufort street in Mt Lawley
You should almost never prescribe oxycodone for someone to take home. It must be discussed with a consultant first. We generally have better, less addictive options available.

- **Social Work**

Like most emergency departments around the world, a significant proportion of our patients have complex social needs. Our expert team of Social workers ensure we're offering as much help as possible to these people.
They are especially keen to know when there has been a death in the department so they can follow up with the relatives so please make a referral to social work on e-referrals if a death happens in the department when they are not around e.g. overnight.

- **Drug and Alcohol Services**

A large amount of our workload is the direct result of drug and alcohol intoxication and dependence. We have Drug and Alcohol Nurses available on Pager 4799 during the day. The spend most of the morning on the Obs ward round linking patients in with appropriate drug and alcohol services but are also available for advice on withdrawal management. They know a lot of our frequent flyers very well and often know exactly what drugs they tend to abuse which can be very helpful information in some resuscitation scenarios.

- **Care Coordination team**

We have resident Physiotherapists and Occupational Therapists resident in the department from early morning till 9pm 7 days a week. They are superb at determining whether someone is safe for discharge and getting services in place to maximise safe discharges. They are very proactive in seeking out elderly patients within the emergency department but are also frequently involved in assessing people with back pain. If CCT advise that they think a patient is likely to go home in the morning you should generally follow this advice and consider admitting them under Obs.
There is also a service called **'CCT 2 Home'.** This provides next day CCT follow up (Monday to Friday) and is especially designed to target:

- Over 65 Falls;
- Over 65 Back pain;
- Over 65 Upper limb fracture living alone;
- Patients refusing services in ED;
- Patients with a stressed carer;
- Patients with frequent ED presentations.

Generally people will be referred to this by our own CCT team but doctors can make referrals also by calling extension 77926 and leaving a message with the patient's name, UMRN and a brief story including a reason for referral.

- **Residential Care Line**

This provides a mechanism of feeding back any concerns you have about a patient referred in from a residential aged care facility. This team will follow up with the home in question and ensure education is in place to improve services. Their outreach service is available 0800-1600 7 days a week. They can be contacted on Extension 73146. Leave a message out of hours and they'll follow up the next day.

Inpatient Admissions:

One of the key skills in emergency medicine is figuring out what you need to do to safely reach your disposition decision. Patients who are obvious admissions should have their bed booked without delay, especially without waiting for test results that are unlikely to change their disposition e.g.

- A CT to rule out a subdural has a small pick-up rate (<5%) and should not delay admission under MAU for an elderly patient with confusion unless you have a very strong clinical suspicion.
- A patient with suspicious sounding chest pain and high risk features should be admitted under cardiology prior to their troponin coming back as its unlikely they'll be suitable for discharge even if it is negative.

Please note inpatient teams do not '**accept'** patients.
We decide who gets admitted and where and then make courtesy call to politely inform inpatient units of their new patient.

Hospital Policy 193 states:
'***Emergency Department senior medical staff have the authority to admit emergency patients to the hospital for inpatient care and determine which specialty the patient will be admitted to.'***

Naturally there will always be a small minority of patients in the grey zone for which consultation with several specialties is appropriate and necessary but these really should be the exception to the rule. Inpatient units do not have the right to use our Short stay ward – DO not be pressured into doing so
Any resistance from inpatient teams should be result in immediate escalation to team leader or duty consultant as necessary.

Obs / Toxicology admissions:

Geographically there is no distinction between Obs and Toxicology. Both are admitted to our 16 bedded short stay ward. Tox patients are basically anyone with an overdose or any hint of drug or alcohol intoxication or a medication side effect.

If you admit someone to Obs, you must document your plan (including a plan B), complete a drug chart and prescribe fluids as appropriate. Finally you must also let the registrar covering Obs (or Toxicology if they're around) ward know – they have right of refusal.
A rule of thumb for Obs patients is patients with single system problems that are likely to be discharged within 24 hours.
Classic examples include: Renal Colic, Gastroenteritis, Tonsilitis, Pyelonephritis; Thunderclap headache with negative CT for LP in the morning; Elderly patient with **confirmed** bed available in Private hospital the next morning; Back pain requiring more intense analgesia.
YOU MUST NOT USE OBS OR TOX FOR PATIENTS WHO NEED ADMITTED BUT YOU'RE UNSURE UNDER WHICH SPECIALTY – This is what your consultants and team leaders are for.

Please note patients requiring ongoing cardiac monitoring or a high level of nursing care are not suitable for obs. The same is true for anyone likely to be a security risk to staff or themselves.

Transfers to Other Hospitals:

These will mostly be transfers to Private hospitals but occasionally patients are transferred to other hospitals because of their condition (e.g. Burns to FSH, Some spinal to RPH.)
Please read the section on discharge coordinators and Private Hospitals above.

Death in the Deparment:

This happens about twice a week and is most commonly the result of an out of hospital arrest that cannot be resuscitated.
There is a '**Notification of a Death in the Emergency Department'** checklist that must be completed by the treating doctor in all cases. This can be found beside the Clerks desk on the flight deck.
Practically all deaths in the department should be discussed with the coronial office as they are usually unexpected deaths – most will not require formal coronial investigation but they are best placed to make that call.
They are best contacted via the Police Coronial Investigation Unit on 0892675700.
Once the decision to refer to the Coroner has been made (i.e. most cases in the ED), all tubes and IV drips must remain in situ until the decision not to investigate is made.

Handover:

You must ensure all your patients are handed over on EDIS and all your EDIS boxes are done before leaving the department. The Duty Consultant will call you on your mobile and request your return to the Emergency department immediately if you leave without doing these things.
There are 3 main departmental handovers during the day: at 0800, 1700 and 2300. Doctors finishing at 1800 and 0830 attend the afternoon and morning handovers respectively. Those finishing at 2000 are expected to handover to their appropriate team leaders at the end of their shifts. It is your responsibility to leave on time. Handover occurs on the flight deck and you are expected to be there on time. An announcement is made over the department's speaker system.
Few things make a Consultant unhappier than people not being punctual to handover.
You must ensure any patient in the department with your name on it has another treating doctor's name put on it before you leave (and that they know about it!).
Learning how to give a succinct handover is another key skill to learn in the emergency department and you are encouraged to stay to the end of each handover to learn from good and bad examples.
You will be expected to explain why any of your patients have spent longer than 4 hours in the department at handover.

A reminder: **NEVER use the handover button on EDIS**.

Online resources

The SCGH library website has many useful links to explore including:

- Therapeutic guidelines – most commonly used for Antibiotic advice.
- Online Journals.
- UptoDate – on site access only unfortunately.
- Online Books – My personal favourite is Roberts and Hedges' ***Clinical procedures in Emergency medicine*** – superb 'How to' guides on everything from aspirating an ankle to putting on a thumb Spica.

The unofficial **ED internet** page scghed.com is the go to place for all our Clinical Guidelines as well as being a repository of all or CME presentations and some useful orientation tools.

Supervisors:

Your term supervisor is your first point of contact if you are experiencing any difficulty in the term. If there are any issues affecting your ability to work, concerns around work safety, or interactions with other staff that you see as unprofessional, we ask that you approach us early so that these issues can be addressed proactively.

Intern supervisor: Dr Jason Armstrong
RMO supervisor: Dr Nick Martin
Registrar supervisor: 2 Co-DEMTs Dr James Winton and Dr Ioana Vlad

Mid and End of Term Assessments:

Intern and RMO Assessments are coordinated by the Toxicologists along with Dr Nick Martin.
Approximately half way through everyone's terms we seek specific feedback on all of you from Consultants, Registrars, Clerical, Admin and nursing staff.
Anyone identified as needing some extra help will get a mid-term assessment to work out a plan of attack on how to make you the best doctor you can be.
Unfortunately we currently don't have time to do formal mid-term assessments for everyone but if you specifically want one or we feel you would benefit from extra help we will perform one. These are always formative rather than summative.

- Intern End of Term Assessments can be completed by any of the Toxicologists
- ED employed RMOs End of Term Assessments can be completed by Dr Nick Martin or any of the Toxicologists. Despite 6 or 12 month contracts it is expected that you will complete a term assessment every 3 months
- Medical Admin employed RMOs End of Term Assessments can be completed by Dr Nick Martin
- Registrars' assessments are coordinated by our 2 Co-DEMTs.

Mentors

All registrars and ED RMOs will have a consultant nominated as a mentor. This should be regarded as an informal support person to provide career guidance and advice. It is not mandatory but you are encouraged to meet up with your mentor at least once. The goals of mentoring include:

- Advice on career progression.
- Confidant, advocate and safety net in case of difficulty on the mentee's part.
- To pass on Hospital / College values and culture.
- Motivation for the mentee to challenge themselves appropriately.
- Provides a safe space to ask questions without losing credibility.
- Help on solving some work related problems.
- Help on increasing professional exposure and networking of the mentee.

Quality Improvement Projects:

All registrars not doing the next sitting of an exam are **expected** to complete a QI project during their terms. This will be a key part of your end of term assessments.
A list of projects will be circulated in the first week of your term and will be allocated on a first come basis. If you have your own ideas you are welcome to suggest them to the QI team for consideration
You will also be given a presentation date at departmental CME where you will be expected to present the results of your project.
This project can take the shape of an audit, development or revision of a guideline or even a formal research project. All consultants are expecting to be asked to supervise at least 1 project a year.
Many of these projects could be turned into a poster presentation at a conference
Interns and RMO's are encouraged to participate also as it will make their CV's stand out in an increasingly competitive job market.

Guidelines:

All can be found at:
scghed.com/clinical-guidelines/

COVID 19

As with most things in life COVID has almost completely changed the way we do things in the ED.
Things continue to change so rapidly the only thing I would suggest is that you have a look at our COVID guidelines page on sgched.com to get the most up to date information at any time.