SCGH ED Handbook

WELCOME TO SCGH ED

The Australasian College for Emergency Medicine was founded in 1981 by Dr Tom Hamilton, the first director of SCGH ED who became the College's first President.
Ever since then this department has built on a tradition of educational excellence and has also maintained strong college links.

Many consultants hold positions with our college – from National and state council Members to Examiners, committee chairs and members.
As a department, education remains our top priority.

Our Department is one of the 3 adult tertiary EDs in town.
In 2024 we saw about 78000 patients which works out as just over 210 patients a day.
70% are in the top 3 triage categories and about 40% of our patients arrive by ambulance.
Our patients are high acuity and complexity - you'll learn to love the 'Charlie's patient'!

SCGH ED is known for excellence in many fields , particularly:

- Clinical Toxicology
- Emergency Ultrasound
- ACEM training

We are also the home of life in the fast lane, the worlds most popular Emergency medical blog.
Training in Emergency Medicine involves Selection into Fellowship Training (starting in PGY3+), followed by a minimum of 5 years of training including work in rural/regional Emergency Departments, Critical Care and a minimum period of Paediatric practice.
If you are interested in undertaking Emergency Medicine training, let us know!

WHO'S WHO

DEPARTMENTAL LEADERSHIP

Peter Allely
Director of Emergency Medicine
ACEM President Elect

Lynda Vine
Deputy Director
SCGH DMR lead

Sandra O'Keefe
Chief Administrator

Nicole Hoskins
Coordinator of Nursing

Substantive Senior Medical Staff

Jason Armstrong
Toxicologist
Medical Director -
WA Poisons Information Centre

Chantelle Badawy
FACEM

Mike Cadogan
LITFL Founder
Fellowship Exam Winner 2003

Tom Cassidy
FACEM

Prof Tony Celenza
UWA Medical school
Fellowship Exam winner 1997

Gayle Christie
FACEM + Medical Director of SJA

Tim Cook
Toxicologist

David Cosford
FACEM

Tor Ercleve
Co-Director of SCGOPH Acute Division

Claire Falzon
FACEM

Eve Foreman
ACEM CAPP Councillor

Ian Gawthrope
DDU

Candice Hanson
Toxicologist
DEMT

Geoff Hawking
ACEM Examiner

Richard Hay
DDU

Kate Jutsum
DDU
Sub Dean of UWA

Nick Martin
FACEM

David Moore
FACEM

Fergus Morris
FACEM

Chris Moseley
DDU

David Mountain
Co-Director of SCGOPH CIC Division
Former AMA WA President

Casey Parker
SMP + DDU
Founder of broomedocs.com

Ovi Pascu
Toxicologist

Sam Phillips
DDU

Dan Pixley
FACEM

Claire Plint
Simulation + Mentoring Lead

James Rippey
DDU
Ultrasound lead
Fellowship exam winner 2002

Lindsay Showers
DEMT

Kavinda Senasinghe
FACEM

Andy Steval
FACEM + RFDS

Ioana Vlad
DEMT
ACEM examiner
Toxicologist

James Winton
ACEM examiner

James Wheeler
DDU

Hakan Yaman
FACEM + RFDS

Emergency Department Administration

Beverley Kingston
Police and legal
Reports Liasion

Karen Quinn
JMO Rosters

Debbie Lloyd
Compliments
PDL reports

Emergency Department Nursing Leadership

Nurse Manager
Marli McGuckin

Patient Flow Coordinators
Nicole Hoogewerf
Carmen Robbins
Jordan Shaw
Leigh Wilkins

Clinical Nurse Specialists
Peter Gelle
Kane Guthrie
Abby Hobson
Hayley Clarke
Jacinta Guthrie

Emergency Care Navigation Centre Nurses
Elizabeth Kariuki
Kelly Miels
Lauren O’Connor
Hannah Solomon
Priscilla Rafferty

Staff Development Educator
Emily Slattery

Nurse Practitioners
Jamie Bawden
Nuria O’Mahoney
Alison Leech

VISION AND VALUES

Like many organisations around the world we have developed our own vision and values to reflect what's important for us

Our vision:

'TOGETHER TOWARDS A WORLD CLASS ED'

Our Values:

TEAMWORK
INTEGRITY
WELLBEING

TEAMWORK
For many, the social aspect of our jobs is the best part of Emergency medicine. We provide the best care for our patients when we work seamlessly across multidisciplinary groups both within our department and across the health system as a whole.

INTEGRITY
We expect honesty, transparency and accountability for all of us.

WELLBEING
Staff wellbeing is paramount. We provide the best care for our patients when we look after ourselves

Acknowledgement of Country

SCGH ED acknowledges the Whadjuk people of the Noongar boodja as the traditional custodians of the land on which our department is located. We acknowledge the wisdom of Aboriginal Elders past and present and pay respect to the Aboriginal communities of today.

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.
Good ED clinicians treat patients with the empathy and compassion they would like for themselves or their family.
Great ED clinicians try to understand what is most important for that patient and provide appropriate care that the patient would think best.

EASY WINS

- **Be punctual.** Repeated lateness is unprofessional, is always noticed.
- **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.
- JMOs MUST seek out their team leader <30 mins after picking a patient up.
- 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 your team leader.
- Document procedures, including code blacks.
- Transition from electronic to paper notes (and print off the electronic notes) as soon as a bed is booked.
- Identify appropriate patients for research projects.
- Don’t organise shift swaps without the OK from ED admin.

DRESS CODE

Hospital policy mandates that attire should be:

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

4 sets of scrubs are supplied to every junior doctor at the beginning of your term in return for a $100 deposit. We expect you to wear the tops while on shift so you can be easily identified as an ED member of staff, and wearing of the pants is encouraged as an infection prevention and control mechanism.

BREAKS

You are entitled to a 30-minute break during a normal shift. For your own wellbeing, you must take this - **especially on night shift**. Please let your team leaders know prior to taking your break and do your best to be flexible so that it will have the least impact on the shop floor.

If you are attending teaching, you should plan to eat your meal during these sessions. Please always remain near the department during your meal break (other than a brief trip if food is bought). This is an Emergency Department – major incidents can occur and may require all hands-on deck immediately.

WORKLOAD EXPECTATIONS

Emergency Departments around Australia are increasingly subject to access block which can make finding a location to see patients challenging. We have attempted to improve this through the creation of our PIT and Observation ward areas and encourage feedback about other ideas to improve patient flow you might have.

In terms of workload, a commonly stated expectation is that you aim to see 1 patient every hour. Often, this will be challenging. However, note that the number of patients seen per clinician is monitored and significant deviations from the mean may result in negative feedback in your assessments.

Multi-tasking and juggling several unsorted patients at once are key skills of an ED clinician. These skills are extremely useful for all branches of medicine, but you may never have the same density of decision-making 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.

PERSONAL LEAVE

You never need to ask permission to take personal leave.
The process for calling in sick is that you must call the duty consultant on 6457 7255 (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 future reference requests from the hospital.
Please give us as much notice as possible - especially if you're calling in sick for night shift. This allows us to potentially juggle rosters around and maybe even put a shout out to anyone interested in an overtime shift.
You can self-certify for up to 2 days sick leave but after that you will need to provide a doctors letter. It is unacceptable and unprofessional to get one of your colleagues to complete a certificate.
Life is complicated and at some stage in our careers external things will happen that will influence our ability to work. If something like this happens to you, we will do our best to support you but please let us know.

ANNUAL/PROFESSIONAL DEVELOPMENT LEAVE

Our admin team have the final say on whether leave will be granted or not.

- Any leave previously approved by SCGH Medical Workforce needs to be double checked with ED administration to confirm that it will be approved.
- Any new leave applications must be submitted directly to ED administration.

It is unlikely that you will be granted leave if you are rostered for nights. Leave around ACEM exam times can also be challenging, however attempts will be made to ensure equitable access for all applicants.
Professional development leave (PDL) applications must be supported by printed evidence that makes clear the relationship between the course and your work.
A Consultant must approve your PDL application prior to it being submitted to admin.
Registrars PDL - Vetted by DEMTs
Intern + RMO PDL - Vetted by Tom Cassidy and Hakan Yaman
You will be expected to submit a report about what you learned from the course / conference.

SWAPS

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 are not breaking safe working hour restrictions, as such please note swaps need to be within the same pay fortnight.

OVERTIME

If anyone wants to pick up some extra shifts - our department offers **voluntary overtime rate shifts on weekends and Public Holidays**. We have space for 1 extra RMO and 1 Registrar on morning and evening shifts - email admin to lock it in.
Occasionally you may be asked to stay late after the end of your shift. We think it's really important you get paid overtime when this happens but we need you to get it verified by the duty consultant at the time. We can't retrospectively approve overtime claims without the Duty consultant signing off on it.

ADMIN

Easy means of communication are essential in ED - before you 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 even after you have left the department.

Please note **early resignation** is regarded as being unprofessional unless there are strong extenuating reasons. It is departmental policy to notify referees of any early resignation.

DIVERSITY AND EQUITY

A core part of Emergency Medicine is teamwork.
Our team is made stronger by the wide variety of diversity that is represented in our staff - regardless of who you are or how you identify you are welcome here. We still have work to do, but we want to ensure the wellbeing of our staff who in turn will ensure the wellbeing of our patients.

Some of the ED specific services we support:
ED Diversity, Inclusion and Equity working group (EDDIE)
- Network of SCGH ED staff
- Structured around the values statement ‘diversity is the strength that holds this complex health system together’
- All are welcome to our regular meetings

Network of Women in Emergency Medicine (NoWEM)
- Started by a group of Emergency Physicians in NSW, now an Australia wide organisation
- Regular meetings held at various sites around Perth including networking and regular guest speakers.
- All are welcome in this group which is based around celebrating and promoting gender equity in medicine

INTERPRETER SERVICES

Many patients who seek assistance in ED will be from culturally and linguistically diverse backgrounds. It is imperative that clear communication is undertaken and in a language that is acceptable to the person. The use of informal interpreters must be avoided where at all possible, and specifically cannot be used for formal interactions such as gaining consent for procedures.

We have two iPads in ED (stored with the liaison clerk on the main flight deck) which have internet connections and will provide ready access to phone and video interpreters in a large variety of languages.

ABORIGINAL LIAISON OFFICERS

Aboriginal people have a long history of disadvantage in Australia, often experiencing complex interactions with health services. It is important to understand this context to provide optimal care.

Our hospital has a team of Aboriginal Liaison Officers who will be happy to come and see Aboriginal patients in ED to ensure culturally appropriate care and follow up is being provided. A specific area of concern is Aboriginal patients who choose to leave ED prior to being seen. The ALO team would like to hear about all these patients via eReferral. In daytime hours the ALO team can be contacted on 6457 6355.

FAMILY MEETINGS

Family meetings occur many times a day in the Emergency Department, and frequently involve conveying bad news to patients or their support persons. We have a family room on the main corridor to triage which is commonly used for this purpose.

These meetings are high risk discussions and should not be undertaken alone, or without the express knowledge of your team leader. Usual practice is for senior medical staff and senior nursing staff to attend together for these meetings to ensure consistency of communication.

Having these sorts of discussions in a sensitive and professional manner is a core ED skill, and junior staff are encouraged to be present at these meetings when they have been caring for the patient. If the discussion is in daylight hours and about a patient who is likely to die, our department strongly advocates for including Social Work in the meeting, as they will be involved in short-term bereavement follow up.

DEATH IN THE DEPARTMENT

This happens about 2 or 3 times a week and is most commonly the result of an out of hospital cardiac arrest that cannot be resuscitated. Second most common is a person who presents having had a catastrophic intracranial bleed who then undergoes terminal care in the ED.

In addition to the Death in Hospital form, there is a ‘Notification of a Death in the Emergency Department’ checklist that must be completed by the treating doctor in all cases. This form, along with all the usual deceased patient forms, are stored with the Liaison Clerk on the main flight deck.

Most deaths in the ED will require discussion with the coroner as they are usually unexpected deaths. Many of these will not require formal coronial investigation but the Police Coronial Investigation Unit are the only people able to make that call. The PCIU are best contacted via phone on 9267 5700.

Once the decision to refer to the Coroner has been made, all tubes and IV drips must remain in situ until a decision not to investigate is made.

QUALITY IMPROVEMENT PROJECTS

All registrars not doing the next sitting of an exam are encouraged to complete a QI project during their term. These are a great way to enhance your CV and improve your chances of being selected onto a training program (not just Emergency). Claire Falzon leads our QI team.

Ideally, you'll have your own idea about improving something that annoys you but if not please feel free to approach the QI team who will happily point you in the right direction.

Due to the time required to achieve approval for any audit, contact should be made with the QI team at the earliest possible point in your term.

TEACHING

Teaching is sacred.
Thursdays are intentionally double-staffed to allow safe staffing levels on the floor while designated people go off the floor to teaching
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.
Teaching is usually held in the ED Seminar room (for Registrars) and the Joske room on level 8 (for interns and RMOs). Simulation training is usually held in the lower OBS simulation room.

THURSDAY TIMETABLE

0800-1100 = General Registrar CME
1100-1300 = Registrar Ultrasound and Tox teaching + getting your lunch.
1300 = Registrars not doing the next Primary or fellowship exam are expected back on the floor (Unless they're on T shifts).
1300-1500 = ACEM primary and Fellowship Exam Teaching.
1330 - 1530 = Clinical Ultrasound teaching for T shift Registrars not doing exams.
1500 – 1800 = Intern and RMO '***Core Knowledge***' teaching.

TEACHING PRACTICALITIES

- Registrars on T shifts are expected to be **<u>on site</u>**. You are welcome to use any of the consultants offices that are not being used at the time.
- Interns and RMOs on day shift should hand all their patients over at 1445 - you are not expected to return to the floor after teaching.
- Interns and RMOs on evening shift must ensure their team leader knows about the patients they've seen between their arrival and leaving for teaching at 1500.
- If you are rostered to give a talk you should chat with the supervising consultant ASAP for ideas / strategy etc.
- If you are unable to give a talk for which you are rostered it is your responsibility to swap out of it.

OTHER TEACHING

ACEM OSCE PRACTICE:

- Protected teaching time for those doing the OSCE in the next 6 months.
- Every Wednesday afternoon from 3.30pm to 5.30pm
- Location: ED Seminar Room.
- Day shift Registrars should handover their patients prior to this.

SIMULATION TRAINING

Our Education registrar and Simulation team run multidisciplinary small group sessions usually in the Sim room in LOBS

- **Registrars**
  - Monday and Friday Mornings 0800-0930
- **Interns + RMOs**
  - Tuesdays 0800-0930

WORKPLACE BASED ASSESSMENTS = WBA'S

Andy Steval and Tom Cassidy are our WBA coordinators for ACEM trainees.
We have a consultant specifically rostered onto a clinical teaching shifts several times a week.
The consultant roster is available via scghed.com (on the 'Intranet' Tab).
Login: Registrar
Password: Registrar1$

For DOPS and shift reports you need to be proactive. – it doesn't need to be during a clinical teaching shift.

MEDICAL STUDENTS

We have a large number of students from UWA, Notre Dame and Curtin Universities that rotate through our department. They will be allocated to a team and rotate through the same shift patterns as JMOs.
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 students 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.

SUPERVISORS

Dr Nick Martin coordinates our assessment processes for Interns and RMOs.
An email is sent out at the start of each term telling you which consultant is your nominated supervisor.
I'd suggest you check the consultant roster via scghed.com (see section on WBA's above for the login) to make sure you can coordinate mid and end of term assessments around your own roster.
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.

If you are not comfortable approaching your nominated supervisor you have several other options:

- Approach the current JMO Representative
    - They meet with our Leadership team on a monthly basis and are happy to forward any anonymous feedback
- Approach any of the other Consultants.
    - If our Director's door is open please feel free to wander in and have a chat.
    - Our Deputy DEM, Lynda Vine is also very happy to chat too.
- Approach your Mentor (see Below)
- Approach the ***Employee Assistance Program***
    - Every employee of WA health is entitled to 3 free counselling sessions 'per matter'
    - This is entirely anonymous. Nobody else will know that you've used the service. Our Chief Executive just gets told the number of employees that have used the service each year.

Registrars are supervised by our 3 Co-DEMTs (Directors of Emergency Medicine training):

- Lindsay Showers
- Ioana Vlad
- Candice Hanson

MENTORS

Claire Plint coordinates our Mentor program.
All Registrars and ED RMOs will have a a mentor nominated.
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.
- Confidante, 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.

MANDATORY TRAINING

It can be hard to keep track of what training modules are mandatory. The most up to date list is kept on the SCGH intranet page - the current link is 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:

- Document all procedures and timestamp every entry into medical notes.
- Document the **names** of any inpatient teams or senior Emergency Doctors you've sought advice from.
- Document the **names** of chaperones you use when performing intimate examinations or procedures. Drs have suffered needlessly in the past from accusations that could have been easily defended with a named chaperone.

Discharge against medical advice:
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.
Also document whatever risks of DAMA you've explained to the patient – the more specific the better.

In Australian common law adults are ***presumed to be competent***.
Demonstrating competence involves four important elements. Patients should demonstrate that they have the ability to:

1. Maintain and communicate a choice
2. Understand and remember the relevant information
3. Appreciate the situation and its consequences
4. Use or weigh the information in a rational fashion

In WA if a person restrains another person without legal authority to do so it may be found to be an assault for deprivation of liberty under the criminal code.
Duty of care DOES NOT provide clinicians with the power to prevent a person leaving the ED if the person has expressed the desire to do so.
If your patient is trying to leave the department and you do not think they have capacity or they may be at significant risk of harm if they leave, you need to involve your senior doctor to assist in making the decision to keep the patient against their will.
The only time we can detain a patient in the ED is either:

- Under the Mental Health Act (WA) 2014 or
- Under the Doctrine of Necessity.

The **doctrine of necessity** can be applied if the patient lacks capacity to make their own treatment decisions, there is a **real and immediate** danger of significant harm to themselves, staff or others, and there is an overriding necessity for the urgent protection of the patient and others.
This decision is made by the most senior doctor available and needs to be clearly documented in the medical records.

DISCHARGE AGAINST MEDICAL ADVICE = DAMA

From a clerical perspective there are actually 3 types of DAMA with important implications for funding so please document the most appropriate outcome on EDIS using below as a guide:

- **DID NOT WAIT** (DNW) = A patient who presents to EDIS but isn't seen by a treating clinician
- **LEFT AT OWN RISK** (LAOR) = A patient who is seen by a treating clinician but chooses to leave before physically getting to a ward.
- **DISCHARGED AGAINST MEDICAL ADVICE** = A patient who chooses to leave ***after*** physically being admitted to a ward - so this really only applies to the OBS ward in the ED setting.

If anyone has particular concerns about a patient that has DNW or LAOR they should escalate their concern to the Duty Consultant or Duty Registrar who may do one of 3 things:

1. No action required
2. Call Police to do a welfare check - will be low priority for Police and might take several days
3. Call Police to consider bringing the patient back for reassessment using '**Section 156**' of the Mental Health act - predominantly used for higher risk scenarios.

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. Effective team leaders will make sure 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%

EMERGENCY CARE NAVIGATION CENTRE = ECNC

The ECNC was introduced in July 2023 in an effort to improve our front of house safety and efficiency.
We also have a dedicated HSA and Phlebotomist along with a Hospital Liaison Manager from St John's Ambulance.
JMOs are not allowed to see patients at the front of the department (unless they have been specifically invited) while the ECNC is in operation - the 2 beds are reserved for the ECNC and waiting room teams.
The role of the ECNC doctor is to get the ball rolling and make a positive impact on as many patient journeys as possible by ordering appropriate imaging and pathology and by sometimes arranging their disposition (eg: discharging from the waiting room or admitting straight to OBS, or getting a bed booked for the MAU team etc).
The ECNC doctor will make a brief entry into the patients clinical notes to guide the JMO that picks up the patient. The JMO should discuss the patient with their designated team leader (and NOT the ECNC).
We anticipate the ECNC role will evolve and grow over the coming months as we introduce a locally developed 'My Emergency Visit' (MEV) App.
Currently MEV is focussed on waiting room safety and is currently being used predominantly by the ECNC consultant and our nursing team.

PITSTOP

Pitstop was introduced Pre-COVID when we realised that the only beds that cant be occupied by inpatients waiting for beds upstairs are our OBS ward bays. OBS beds 1-5 are in close proximity to the waiting room so we sacrificed cubicle 3 and put a new door in to allow rapid access into and out of the waiting room

The Goal of Pitstop is to keep vertical patients vertical!
Patients who are otherwise stuck in the waiting room are

- Brought into a proper cubicle,
- Get a Hx and Examination.
- Have investigations and treatment commenced.
- **Get put back out into the waiting room** pending results or a bed elsewhere in the department.

A Consultant is rostered to Pitstop with a small team of JMOs from 0800-2400. Other JMOs can see patients in Pitstop (and often it's the only place where beds are available).
After 2200, Pitstop moves to fast track to allow patients admitted to OBS to get some sleep without doors constantly opening and closing.

TEAM BASED CARE

At the start of each shift you should check the ED Day sheet to see which part of the department you have been allocated to and who your team leader is and report to them prior to seeing any patients.
As a team member you must take from the top of the EDIS list i.e. the next patient who hasn't been allocated a treating doctor already. If they have a named senior doctor already you should still pick them up and become the treating doctor unless directed otherwise by your team leader or the duty consultant.

HANDOVER

There are 3 main departmental handovers during the day: at 0800, 1730 and 2230. All staff are expected to attend the 0800 Handover and report to their team leaders **prior** to seeing any patients.
The 1730 Handover will be led by the evening team leaders. Others on evening shift should just continue seeing patients.
Handover occurs on the flight deck. 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 how others do it.
A reminder: **NEVER** use the handover button on EDIS.

ROLES AND RESPONSIBILITIES

TEAM MEMBERS:

- See multiple patients concurrently.
- 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 investigations.
- Complete boxes on EDIS as you go.
- You must not leave the department until all EDIS boxes are done.
- 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. Actively allocate patients to team members rather than waiting for them to pick patients up voluntarily.
- Ensure all inpatient beds are booked << 3 hours after patient arrival.
- Ensure Obs patients are reassessed and discharged in a timely fashion.
- 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 and manage your teams resources efficiently by de-escalating your team members ASAP.
- Make sure your team get their breaks - especially on Night shift.

DUTY CONSULTANT / OVERNIGHT SENIOR REGISTRAR

- Do a roll call at the start of every shift
- Ask admin to contact any staff unaccounted for.
- Adjust day sheet teams as necessary post sick calls.
- Be a positive role model for the entire department.
- Work closely with the nursing Shift Coordinator and Flow Coordinator, in particular notifying them of any formed or high acuity patients that are incoming.
- Maximise usage of Obs.
- Police bed booking times.
- Carry DECT phone 77255 to receive calls about:
  - 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.
  - Pathology + Radiology re: abnormal results
  - Triage
    - Advice on complex triage decisions.
  - Switchboard re: codes
  - Hospital Public relations team (Rarely)
- 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
- Supervise any handovers between non-consultant team leaders.

ECNC Consultant

- Screen incoming patients looking for ways to add value to their journey by:
  - Initiating Pathology and Radiology
  - Cherry Picking the ‘Easy Disposition’ patients:
    - Direct to OBS ward
    - Direct Inpatient Admissions
    - Direct discharges from WR
    - Get patients off the ramp as much as possible via ‘Fit to Sit’ + Hot swaps.
- All patients should have ECNC added as the Senior doctor and should have a brief Clinical notes entry put in by the ECNC Consultant.
- JMOs who pick up patients seen by the ECNC Consultant still need to run the patient by their team leader.
- JMOs are not allowed to see patients out the front or use the Phlebotomist.

PITSTOP DOCTORS

- All patients in the waiting room should be considered as eligible for PITSTOP apart from:
  - Potential Security risk patients.
  - Patients needing PPE for infection control reasons.
- The PITSTOP nurse will bring patients in from the waiting room
- Doctors should also do this if the nurse is busy.
- The patients location must be kept up to date on EDIS.
- PITSTOP team JMOs should run their patients via the PITSTOP team leader.
- Other JMOs can use PITSTOP beds but should run their patients by their designated team leader.
- Inpatient teams can use PITSTOP to assess patients but they **must** return them to the waiting room afterwards.
- Patients that are deemed not fit to return to the waiting room should be prioritised for transfer to the main department (or OBS).

FAST TRACK

- Doctors in Fast track report to the Duty Consultant for any clinical queries
- Patients are flagged as potential FT patients by our triage nurses but doctors should trawl the waiting room looking for other patients that could be managed through Fast track.

OBS INTERN

- Prior to the morning ward round starting the Obs intern must
  - Ensure all EDIS clinical notes have been printed off for the OBS round
  - 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.

CHARLIE'S ED

OBS REGISTRARS

- Patients remain under the governance of the treating Dr until the end of their shift when they are handed over the the nominated OBS Registrar.
- The Obs registrar should strive to make even a rudimentary line in the medical notes of all patients in the Obs ward to maximise coding.
- The Obs registrar does not attend teaching on Thursday mornings.
- On Saturdays and Sundays, the outgoing day Obs reg should handover to whichever registrar is not team leading.

OVERNIGHT REGISTRARS

- 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.
  - Any difficult decisions related to holding patients against their will.

PAPERWORK + DOCUMENTATION

- Notes are written via the EDIS clinical notes function until a patient is admitted
- Patients that are admitted (OBS and inpatients) – print off their notes whenever a bed is booked and transition to paper notes from then on.
- Patients that are discharged – print off their EDIS notes and give them to the clerks.

Once you've printed off 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 aim for the 'Goldilocks zone' in that you write just enough - not too much and not too little.
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

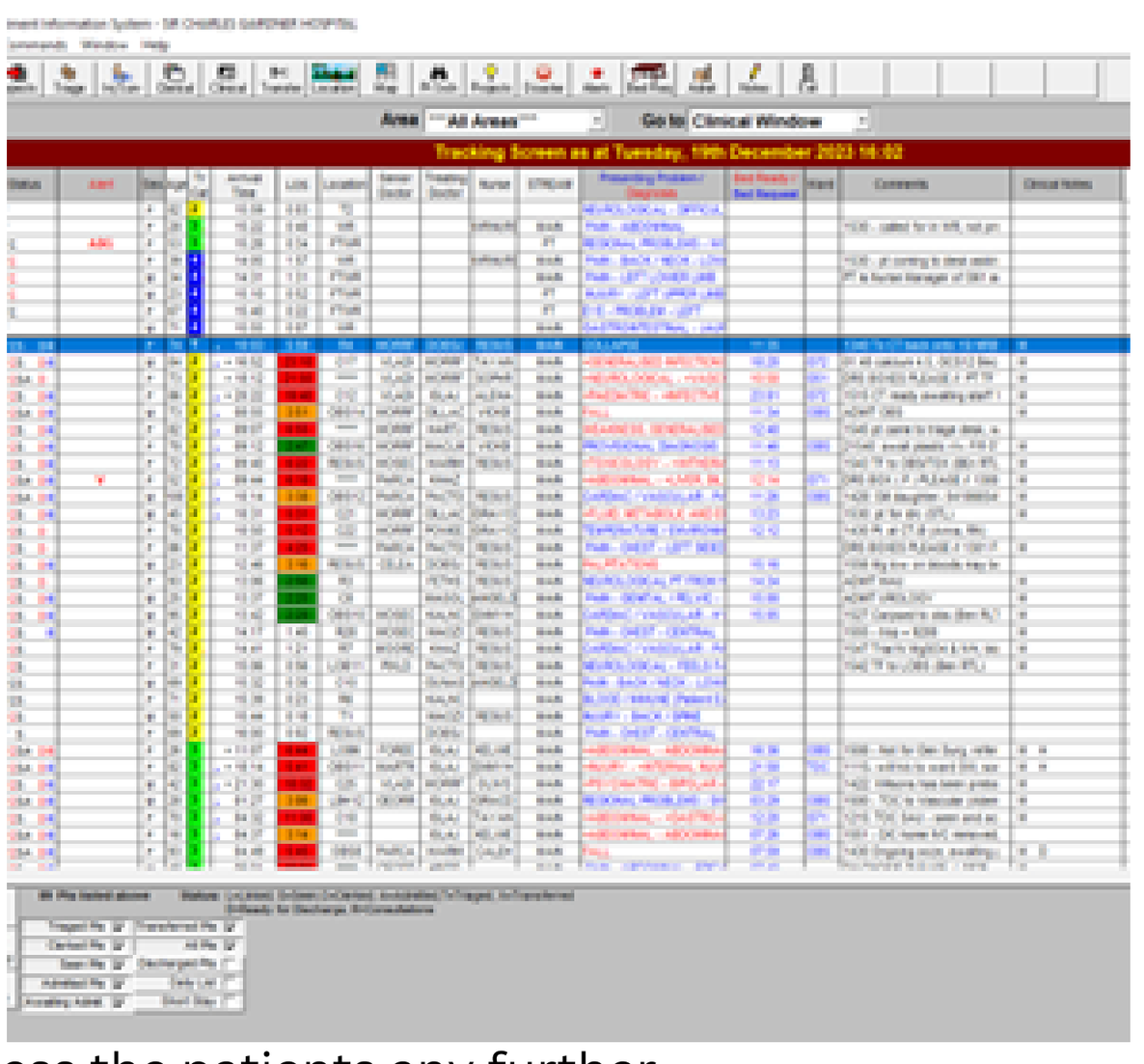
Unfortunately, you will need to become familiar with multiple computer programs to be able to care for your patients appropriately. All of these are best learned from actually using them, but a brief overview of hints and tips will hopefully let you see which bits we think are the most important. If you have any IT issues with passwords etc, our ED Admin team can usually sort it quite quickly so dont suffer in silence and ask for help!

SINGLE SIGN ON

This takes less than 30 seconds to register for the first time and then ***theoretically*** every computer in the department will remember most of your logins.
Get it sorted on your first shift. If it doesn't work **ASK ADMIN.**
Remember to tag off after using it, otherwise someone else can order tests with your name

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.



<u>A few useful tips:</u>

- **'Doing Your Boxes'** means ensuring the following 4 boxes have been completed:
  - Primary Diagnosis
  - Consultations
  - Investigations
  - Procedures
- '**Boxes**' need done as the clerks can't process the patients any further.
- **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.
- **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 of the computer under HEALTH APPS.
- A great way to access **My Health Record** – in the app links tab
- Most used for pathology results checking and radiology eOrdering.
- Pathology eOrder has been recently reintroduced and you are welcome to use it.
- Please note ONLY the ECNC or Duty Consultants can use the Phlebotomist.
- iCM also contains recent discharge letters from most Metropolitan Hospitals.
    - Can be essential reading in code situations
- Can be customised to create your own lists.
- 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 KPI's.
- 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' browsers but can also be found via the intranet link on the scged.com homepage.
- There are 4 **mandatory** boxes to complete.
    - Specialty
    - Admitting consultant
        - Best found by checking the 'Daily Roster' intranet page.
    - Diagnosis
    - Past Medical History
- Please note you should never put any information in the past medical history. Simply put 'x' in the mandatory field.
- **<u>Quirks</u>**
    - **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 on-call person..
    - **ICU** patients also need to be admitted under an inpatient team
        - The Inpatient 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 prefer to make most outpatient referrals 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.
- Doctors are rubbish at checking catchment areas that people live in. If you make a referral that is rejected because the patient is out of catchment area, it is your responsibility to sort it out.
- The simplest policy is to send all patients back to their GPs to get the outpatient referral made despite what inpatient registrars frequently advise. Inpatient registrars are also rubbish at checking catchment areas!

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.

PRO TIP:

You can quickly transfer your EDIS Clinical notes to Communik8 automatically:

- ·Make sure the 'included on Discharge letter' is ticked for all Clinical note entries
- Click on the 'Letter Summary' icon on the clinical page.
- Click 'Edit'
- Click 'OK'
- Close the Letter Summary.

The EDIS Clinical notes will now have transferred to the patients Communik8 letter.

For the majority of our patients, the automatically generated letter is adequate however in patients where GP follow up is particularly important please give the patient 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 the fax machine doesn't work).
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.

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

We have recently started a Phlebotomy service in ED.
They are based at triage and work with the ECNC team at the front of house.
Only Consultants are allowed to request bloods via the Phlebotomy service.

Does your patient really need a cannula?
Around 50% of the cannulae we place in the ED never get used.
James Rippey is one of the world leaders in research around IV access in Emergency departments. His research gives us a rule of thumb that we should only put a cannula in if we think it's **80% likely** that something will be given through it.

You must use sterile gloves while maintaining a sterile field when placing an IV cannula. The days of using an alcohol wipe are gone and nursing staff are rightly very intolerant of any doctors who think otherwise.
The Antecubital fossa is the worst place in the arm to put a cannula in - they're much more likely to become infected and have a much shorter lifespan because of elbow flexion - If you can, save it for situations where volume resuscitation is likely to be required and avoid it in other situations.

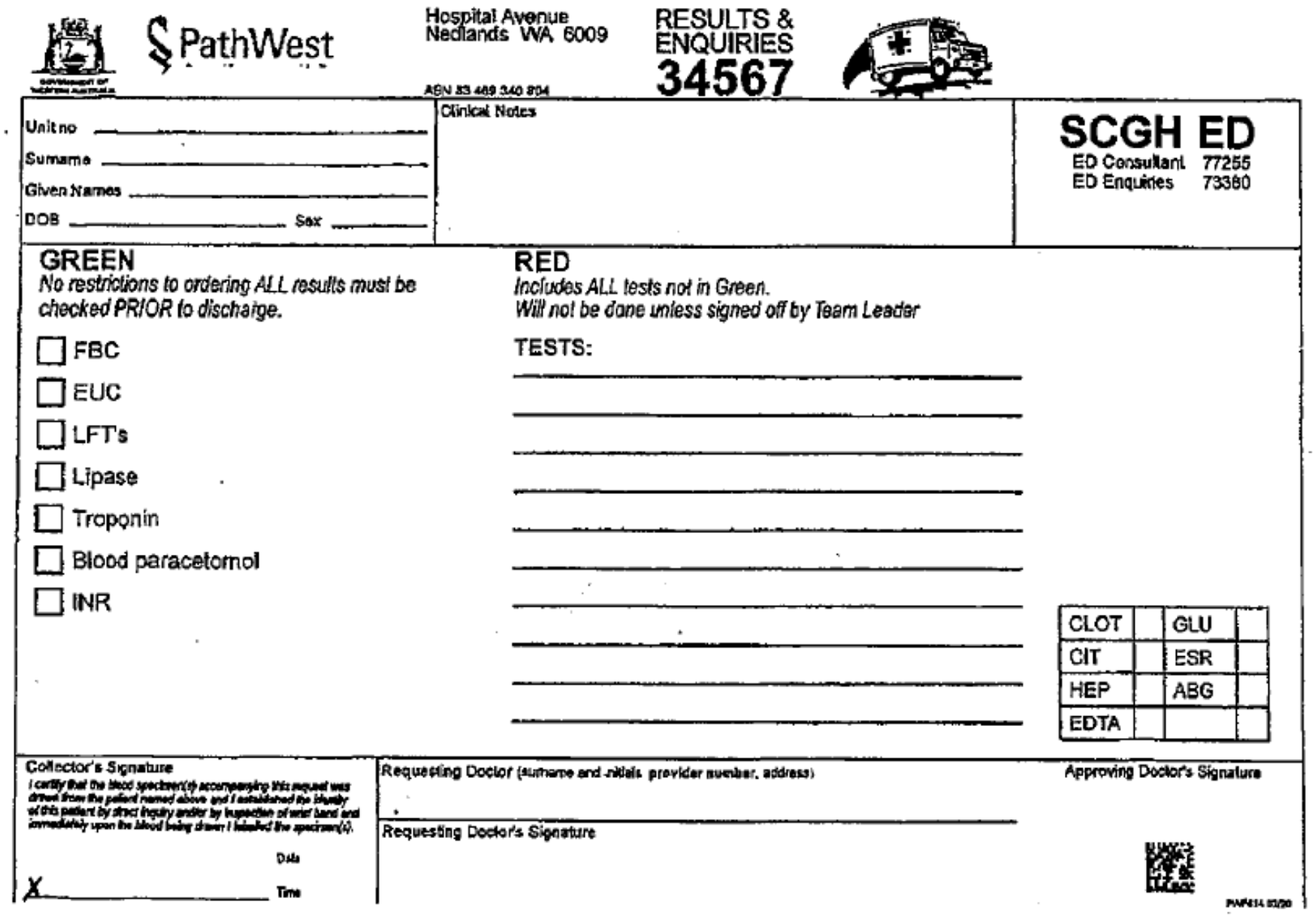
It is ***YOUR*** responsibility to dispose of your sharps and tidy up your mess afterwards.

Each year about 2 patients die in SCGH because of sepsis related to peripheral lines placed in the ED.

You are not allowed to attempt US guided cannulation unless you have got signed off by one of our DDU consultants - we've seen some horrendous aseptic technique from unaccredited JMOs. James Rippey has developed some free training modules which can be accessed on www.sonocpd.com

ORDERING BLOOD TESTS

Our e-order is different from that used by the rest of the hospital and involves bedside label printing after scanning the patients armband.
We also use a very basic paper form (See next page) where you are only allowed to order the listed tests on the sheet.
Any other test needs to be signed off by your team leader



PathWest

Hospital Avenue
Nedlands WA 6009

ABN 83 469 340 804

RESULTS & ENQUIRIES
34567

Unit no
Surname
Given Names
DOB Sex

Clinical Notes

SCGH ED
ED Consultant 77255
ED Enquiries 73380

GREEN
No restrictions to ordering ALL results must be checked PRIOR to discharge.

- ☐ FBC
- ☐ EUC
- ☐ LFT's
- ☐ Lipase
- ☐ Troponin
- ☐ Blood paracetomol
- ☐ INR

RED
Includes ALL tests not in Green.
Will not be done unless signed off by Team Leader

TESTS:

CLOT		GLU	
CIT		ESR	
HEP		ABG	
EDTA			

Collector's Signature
I certify that the blood specimen(s) accompanying this request was drawn from the patient named above and I established the identity of this patient by strict inquiry and/or by inspection of wrist band and immediately upon the blood being drawn I labelled the specimen(s).
Date
X Time

Requesting Doctor (surname and initials, provider number, address)
Requesting Doctor's Signature

Approving Doctor's Signature

PAP414 03/20

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?**' This is partly why we encourage you to come and chat to us within 30 minutes of picking a patient up - so that you can learn that sometimes it's OK to not order any tests!

VBGs:

- Only Consultants, Registrars and Senior nurses have access codes for the blood gas machines.
- The blood gas machines should really only be used in critically unwell patients or in patients for whom it is the only blood test required before they are discharged (eg: spurious hyperkalaemia from the community)
- If you feel your patient needs one, please ask your team leader for their code.
- Blood gas use is monitored every month and outliers get their access revoked!

Blood Cultures:

- Blood cultures are rightly regarded as a standard of care for ***inpatients*** with fevers.
- The ***opposite*** is true in the ED where they've been shown to change management in < 1% of cases and create a whole lot more potentially harmful false positives.
- Generally, they should only be sent in the critically unwell, returned travellers and the immunocompromised (– e.g. Chemotherapy, steroids, alcoholics) or if your differential includes endocarditis.
- If you decide to do blood cultures please note you are committing yourself to doing 2 sets from 2 different access sites.

Urine Testing

Always check if a dipped urine was actually a midstream specimen.
If it wasn't, there's no point in sending it for culture.
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 ***PLEASE*** document which antibiotic in the clinical comments section of EDIS. The consultant doing microbiology results acknowledgement in 2 days' time will be highly impressed!

RADIOLOGY

We have great clinical decision rules for many parts of the body eg Ottawa Foot, Ankle and Knee rules, NEXUS and Canadian CT rule. We should use them to minimise our testing. We recommend having MDCALC on your phone for easy reference.
Contrary to popular practice, plain abdominal films are a low value test 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!

We have recently moved wholesale to eOrder for Radiology - also on iCM but annoyingly on a different button from Pathology e-order!
Paper forms should only be used for IT downtime and for giving to patients to get outpatient imaging privately (all private firms will accept our forms)

CT Scans:
We no longer need to speak to Radiology about ordering most CT scans but please rationalise your use as much as possible. eg: Is there any reason to do a CT scan on a 99 year old who doesn't want brain surgery?
The exceptions which still require discussions are CT abdomens (with Radiology Reg) and when we need to do a CTA of the head outside of a code stroke. The NIISWA fellow needs to sanction these during hours, with the Radiology Reg vetting it outside of hours.

Ultrasound Scans:
The majority of US scans are performed by our dedicated DDU team.
On shifts when they are not available all emergent ultrasounds must be discussed with a radiologist. If a scan is non-urgent they can be sent home with a request form to arrange the US via a private provider and follow up with their GP.
Please follow the DVT guideline with advice to scans in patients that present out of hours.
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.

Nuclear Medicine:
V/Q scans are an important part of our PE pathway. All requests must be discussed with the on call 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 Scans
Most MRI requests from the ED are in reference to excluding cauda equina emergently – see the ‘Suspected Cauda Equina Pathway’ on SCGHED.com.
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. A lot of them bulk bill - meaning they will be done at no cost to the patient.
We should not be asking the Neurosurgical team for their opinion on whether someone needs an MRI or not.

EMERGENCY CODES

We average about 4 **‘Priority 1’** patients a day.
We get pre-notified by the ambulance crew via the Bat phone for the majority of these. The Bat Phone should preferentially be answered by Consultants or Registrars, but if no one else is around get as much information as you can, document it on our fluoro yellow sheets and follow the idiot’s guide attached to the wall immediately below the phone, seeking out a senior doctor ASAP.

All priority 1 patients are announced by 3 bells over the speaker system but sometimes the triage nurse will announce ***‘Code team to resus’*** over the speaker system too.
If you hear the 3 Bells, stop what you’re doing and immediately report to Resus.
Your team leader will de-escalate you if you’re not needed but attendance is mandatory - it’s far worse to have too few Drs to look after a really sick patient.
Some codes 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:

TRAUMA CODES

There are 2 levels of trauma team activation:

- **ED Trauma** – Notification only pages to general surgery, anaesthetics and radiography
- **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, Cardiothoracics 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, **Midland** and **Joondalup** are the 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.
During hours the Consultant neurologist is very often present within minutes to help with these complex decisions.

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 oral or intravenous sedation.
Physical restraints are a last resort and their use is a decision for the most senior Dr in the department at the time, bearing in mind that the safety of our staff is paramount and assaults on staff are not infrequent.

CODE STEMI

There are strict criteria for calling a code STEMI.
Please refer to the flowchart on the next page and in the guidelines section of scghed.com.
Only the ***most senior docto***r 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 or meets any of the 'Discuss' criteria.

- **Business hours:**
    - Go to the Cath lab ***immediately*** unless the patient is unstable.
- **After hours:**
    - **15 minutes** after activation is the magic number.
    - ***Prehospital activation?***
        - SJA go directly to the cath lab if more than 15 minutes away.
        - If closer - SJA wait in ED until 15 minutes post activation and then go to the cath lab.

Sir Charles Gairdner Hospital

Department of Cardiovascular Medicine, Emergency Department and SJA

SCGH Code STEMI Protocol

Is it an Acute STEMI?

Pain <12/24

ECG Changes consistent with STEMI:

- ST elevation >1mm in 2 contiguous limb leads (**not aVR**) or
- ST elevation >2mm in 2 contiguous chest leads on a **standard 12-lead ECG**

Does it meet criteria to Activate "CODE STEMI"?

Inclusion Criteria:

- Symptom onset <12 hours
- <85 years
- Ongoing pain
- Mobile and independent

Exclusion Criteria – For Discussion:

- >85 years
- LBBB
- Prior CABG
- Significant comorbidities
- Out of Hospital Cardiac Arrest
- Pulmonary oedema
- Cardiogenic shock
- Recent major surgery (<2/52)
- Active bleeding

ED Consultant/Night SR discuss with on-call General Cardiologist (Not Cardiology Registrar)

Is Primary Intervention Appropriate?

	YES	**NO**
Activate "CODE STEMI" Where appropriate	ED Consultant/Night SR **DIAL 55 STATE "CODE STEMI ED NOW"**	Medical management

Patient Preparation in ED

- Aspirin 300mg
- Heparin 5000 IU IV

Is the Patient Stable?

	YES	**NO**
Assess stability & Transfer to Cath Lab (CVIL)	**STABLE PATIENT** • Record time of arrival on ECG • **Transfer with Cardiology Registrar and either SJA Officers or ED RN:** ○ **Work hours 0730-1700, transfer without delay** ○ **After hours, transfer 15 minutes after Code STEMI activation** ○ **Transfer staff to stay with patient until CVIL team members arrive**	****UNSTABLE PATIENTS** = NOT for rapid transfer to CVIL** eg cardiogenic shock, pulmonary oedema, recurrent ventricular arrhythmias • Call **Duty Anaesthetist (DA) Ext 71242** • R/V in ED by DA, Cardiology Registrar and ED Consultant. • ***Remain in ED until CVIL team members arrive and call for patient*** • ***Transfer to CVIL with ED RN, Cardiology Registrar and DA or ED Consultant.***

CODE STEMI
PREHOSPITAL ACTIVATION

All ambulances in metropolitan Perth are now fitted with 12 lead ECG monitors that can transmit via email to the computer beside the Batphone and to our fax machine.
Once they send an ECG, they will ring the Batphone. Their pre-hospital activation protocol is meant to exclude any borderline patients, but you must still double check the patient's history and background.
No matter how horrible the ECG looks, the ***only decision*** we have to make about them is whether they meet STEMI criteria or not.
If it doesn't meet STEMI criteria, the advice to SJA should be to proceed to their closest hospital (which could still be us.)

If you're satisfied the ECG is diagnostic and the patient doesn't meet any exclusion criteria, the most senior Dr in the ED activates a code STEMI by dialling 55.

Check out the ECG section on Life in the Fastlane if you want to upskill your ECG skills

LIFE IN THE FASTLANE

DISPOSITION

This is the word we use to describe the patients destination after the ED. There are 5 possibilities for our patients:

- Discharged home. (or normal abode e.g. Nursing home / Prison)
- Admitted to inpatient team.
- Admitted to Obs or Toxicology.
- Transfer to another hospital.
- 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.
When discharging Nursing Home patients (Residential Aged Care Facility = RACF patients):

- Let the Next of Kin know (if the patient consents)
- Contact the Nursing home to let them know the patient is returning
- Print off a discharge summary
- Book ambulance transport via our liaison clerks on the flight deck.
- Refer the patient to the ***Residential Care Line*** for next day support to the RACF to reduce the risk of the patient bouncing back

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

A team of highly experienced nurses can help us expedite patients back to their RACF and transfer patients to private hospitals.
In general we should avoid sending patients to private hospitals as it is more time consuming than it should be, the ***Ambulance transfer will cost the patient around $1000*** and beds are often rescinded even after a patient is initially accepted.
Long story short -**Do not refer patients to private hospitals unless:**

- It makes good clinical sense - eg: Private Oncology patient presenting with chemotherapy side complication.
- The patient insists - even then you are not obliged to do this if we are too busy. We would much rather you spent your time seeing another patient rather than spending an hour doing all the admin that needs done prior to a private transfer.

Hospital-in-the-Home (HITH) and Silver Chain

HITH has recently been relaunched at SCGH and should be considered the first port of call for patients who could potentially be managed at home - see flow charts on scghed.com and on posters around the department for information on how to refer, inclusion and exclusion criteria and current catchment areas.
Silver Chain is a not-for-profit organisation and is another referral option that is free to the patient that may be able to help if HITH cant help.
Check out their website to figure out which service you should refer to.

PHARMACY

Our ED Pharmacists are available during the day to provide any pharmaceutical advice you might need.
Patients aren't 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: Beaufort street in Mt Lawley is open to 2am
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.
You should also never prescribe Methadone without clearance from our Pharmacy or Drug and Alcohol team.

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 here 7 days a week during the day but if you make an e-referral out of hours they will generally follow them up the next day.
Consider Social Work referral for (not exhaustive):

- All deaths in ED
- Family and domestic violence
- Minors lacking family or social support
- Elder abuse
- Older adults or NDIS issues impacting safe discharge

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 Monday to Friday (at present). They 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 special Physiotherapists and Occupational Therapists who together form our **Care coordination team.**
They are in the department every day from early morning till 2100.
They are often much more important than the medical team in determining whether someone is safe for discharge or not 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 and vertigo.
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 to 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.

INPATIENT ADMISSIONS

Patients who are obvious admissions should have their bed booked immediately, 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.

Please note inpatient teams do not ‘accept’ patients , they get politely informed of admission.

SCGH Hospital Policy states:
‘ED Physicians and Registrars have the authority to admit emergency patients to the hospital for inpatient care.’

Naturally there will always be a 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.

OBS + TOX ADMISSIONS

We are very aggressive in our use of our OBS ward and put nearly as many patients through it as we admit to the rest of the hospital combined.
Geographically there is no distinction between Observation and Toxicology beds. Both are admitted to our short stay wards (Upper and lower OBS).
Appropriate TOX admissions are any overdoses or drug / alcohol-related presentations. This only affects who takes over the governance the next morning so don't get too hung up on the distinction.

The only inclusion criteria for OBS ward is that you need to be 90% sure that they’ll go home within 24 hours

If you admit someone to OBS, you must document your plan (including a plan B), complete a drug chart and prescribe fluids as appropriate. You maintain clinical governance of the patient until the end of your shift.
Classic OBS admissions include:

- Renal Colic,
- Gastroenteritis,
- Tonsillitis,
- Pyelonephritis;
- Thunderclap headaches
- Back pain

It is not appropriate to use our short stay ward for patients who we think need an inpatient admission but we’re just not sure under which specialty – Your team leaders can usually help you with this decision.

THE GERIATRIC ASSESSMENT TEAM (GAT)

We now have a permanent group of Geriatricians with a multidisciplinary team based within the ED 7 days a week.
Their main aim is to turn around and divert elderly patients who would otherwise be admitted to MAU but could go home or to rehab within 24 hours.
They work closely with the obs team every morning.
Occasionally their workload will allow them to see patients the same day rather than the next day so feel free to give them a call if you have a patient you feel they might be able to help you with.
You should only admit someone to OBS pending GAT review the next day if you feel the patient can realistically go home or to a rehab bed the next day.

SCGHED.COM

scghed.com is our official departmental website and is particularly great for:

- Finding all our **clinical guidelines**
- Finding links to **intranet** pages (via the 'intranet' drop down in the top right corner) eg:
    - SCGH Hospital library site
    - Patient Discharge leaflets
- Looking at the consultants roster to figure out who is rostered to clinical teaching when you are on.

HOSPITAL LIBRARY SITE

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

- Therapeutic guidelines – most commonly used for Antibiotic advice.
- Online Journals.
- UptoDate
- Online Books eg:
    - Roberts and Hedges' ***Clinical procedures in Emergency medicine***
        - superb 'How to' guides on everything from aspirating an ankle to putting on a thumb Spica.
        - **Toxicology Handbook.**
            - Australian Tox bible written by our own consultants.