PRESENTING PATIENTS IN THE EMERGENCY DEPARTMENT

Dr David Prisk, FACEM
Emergency Physician
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Handover times

- 07:00
- 16:00
- 23:30

- Be on time for handover.

- Handover is a time to present patients and to listen & learn from your junior colleagues and from senior doctors.

- You will be present for the entirety of handover unless given permission to leave by the ED consultant.

Presenting patients

- Present all patients to an ED consultant or registrar first.
- There is an ED consultant in the department from 07:00 to midnight every day.
- We expect to hear about each and every one of your patients within 20 minutes of you seeing them.

Presentation structure

- All presentations should be concise but complete.
- Every presentation is a story.
  - There should be a beginning, a middle, and an end.

THE BEGINNING

- Introduce your patient.
- Tell us why they are in the ED (what is their chief complaint?)

The middle

- Challenges
  - Investigations
  - Treatments
  - Rationale for the above
  - The results and response

The end

- Where are you going with this patient? What do you think might be wrong with them? Why?
- What is the plan for their ongoing care / assessment / treatment?
- You must formulate a plan.
  - Simply repeating the beginning and middle is not enough.

Referring patients

- You must have a well structured, coherent, concise presentation of your patient when referring patients for admission.
- This is important so that the registrar or consultant to whom you are speaking knows without a doubt why you are referring the patient.
- It is also important so that the registrar or consultant knows without a doubt how severely ill or injured your patient might be. This will help them prioritise the many patients for which they are responsible.

HANDOVER

- There are many formally structured ways to organise your thinking and so organise your patient presentations.
- ISBAR
- IMIST AMBO

ISBAR

- The ISBAR communication framework is used to create a structured and standardised communication format between health care workers. It is particularly useful for reporting changes in a patient's status and / or deterioration between health care services or shifts. – *Canterbury District Health Board*

- ISBAR is also helpful when speaking to an inpatient registrar or consultant about a patient you want admitted.

ISBAR

- **Identification**
- Identify the person to whom you are speaking
- Identify yourself, occupation and where you are calling from
- **Situation**
- Identify the patient by name, date of birth, age, sex, reason for admission
- Identify what is going on with the patient (Chest pain, nausea, etc...)
- **Background**
- Give the patient's presenting complaint
- Give the patient's relevant past medical history
- Brief summary of background
- **Assessment**
- Vital signs: heart rate, respiratory rate, blood pressure, temperature, oxygen saturation, pain scale, level of consciousness
- List if any vital signs that are outside of parameters; what is your clinical impression
- Severity of patient, additional concern
- **Recommendation**
- Explanation of what you require, how urgent and when action needs to be taken
- Make suggestions of what action is to be taken
- Clarify what action you expect to be taken

IMIST AMBO

- The IMIST AMBO system developed by the NSW ambulance service is a way to communicate vital information quickly to another provider.
- You may shorten your presentations to IMIST (with room for some variation).

IMIST

- **I**dentification. Name, age, gender, bedspace in ED
- **M**echanism of injury / **M**edical complaint. What is wrong with this patient? Why are they in the ED?
- **I**njuries identified / suspected or **I**nformation related to medical complaint. Include acute and chronic medical history, medications, social history if relevant
- **S**igns and symptoms. Relevant parts of physical exam, including vital signs.
- **T**rends and treatments. What have you done for your patient? How are they responding to your treatments? What are you going to do with your test results? What is your working diagnosis? Why? What have you excluded?

AMBO

- **A**llergies
- **M**edications that your patient regularly takes including prescription and over the counter drugs.
- **B**ackground. This includes other history that's relevant to the particular case.
- **O**ther information, which includes scene characteristics such as how the patient was found or who they were with, as well as cultural or religious considerations.

Example

- Wiremu is a 54 year old diabetic hypertensive man who came in by ambulance with a 3 day history of central non-radiating chest pain on exertion. He gets sweaty and a bit short of breath when he has pain. 10 years ago he had 2 coronary artery stents placed but was discharged by cardiology 6 years ago. His ECG shows biphasic T waves in V1-V3. He's pain free now after having aspirin and fentanyl in the ambulance. He's a bit hypertensive but his other obs are normal. I think he's got Wellen's Syndrome and needs to be admitted. Bloodwork and chest x-ray are pending.

HANDOVER

- Either method can be used to present patients to an ED consultant or registrar or to an inpatient specialty consultant or registrar.
- Either method can also be used in the 3 handovers that occur during the day.
- Either method will help organise your thoughts and make your presentations clean and clear.
- Either method will also leave absolutely no doubt about what you expect of the registrar or consultant to whom you are speaking.

HANDOVER

- Handover is a critical event.
- Patients can be injured or killed if it is done poorly.
- Work hard to make your handover / patient presentation of the highest possible quality.