# Palmerston North Hospital Emergency Department

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Emergency Physician

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# The Emergency Department

- ~48,000 presentations per annum

- 13 Acute beds
  - 9 resuscitation / centrally monitored beds
    - Of these 9, 2 are large trauma / true resus rooms (R1 and R2)
  - 3 assessment beds
  - 1 negative pressure room
- Subacute area
  - 5 beds, 3 chairs
  - 1 interview room for Acute Care Team (mental health)
  - 1 eye room
- 9 beds in ED observation area (EDOA)

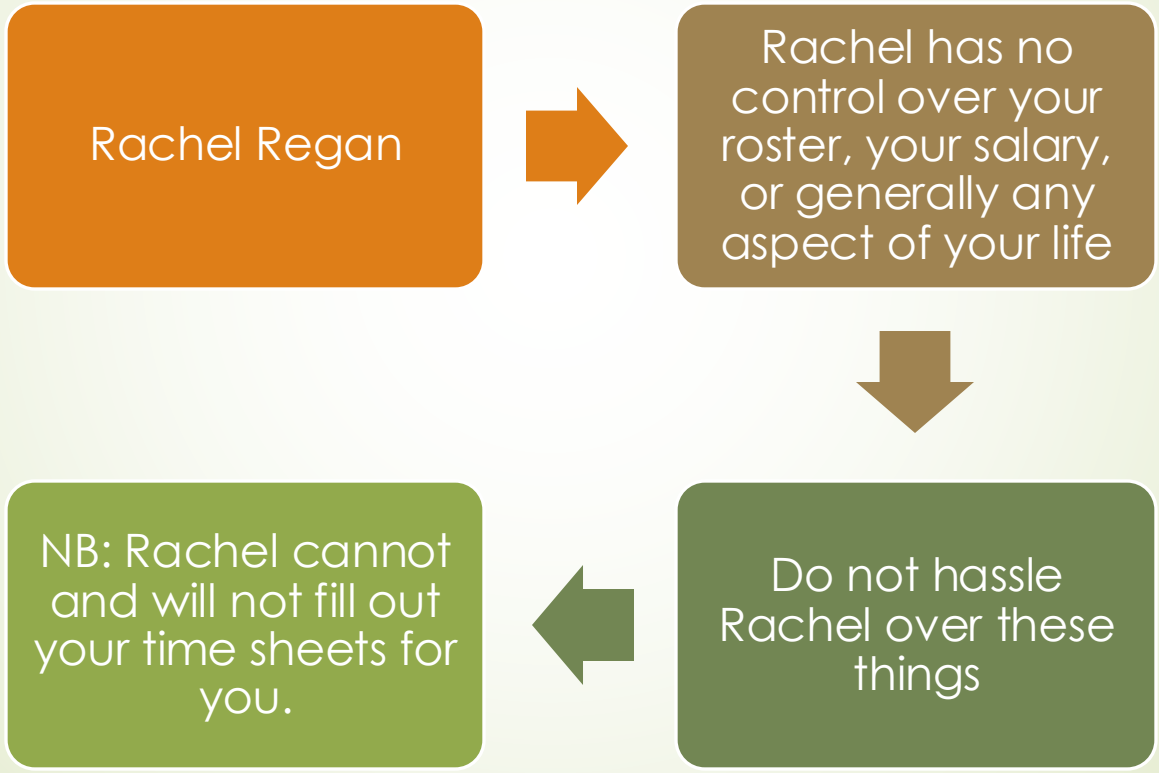
# Medical Leadership

| | | |
|---|---|---|
| 13 consultants | All but 2 are Fellows of the Australasian College for Emergency Medicine | The 2 are in the process of becoming FACEMs |
| Consultants trained in New Zealand, Australia, UK, USA, South Africa, Canada | Co-Medical Lead: DP | Co-Medical Lead: OA |
| Director of Emergency Medicine Training: CU | Every consultant has a special interest / responsibility | Funded and accredited for 10 ACEM registrars and accredited for 2 years of EM training |

# Nursing Leadership

- > 40 FTE RNs
- 3 Clinical Nurse Specialists
- 3 Nurse Practitioners
- Charge Nurse
- 7 Associate Charge Nurses
- A few senior nurses

# ED Administrator



# Consultant Shifts

- 07:00-17:00
- 12:00-22:00
- 14:00-midnight & on call overnight

- For the weekday morning shift, there will be one or two consultants. We work in teams based on shift time.

- Weekends will only have 1 consultant in the morning and 2 in the afternoon. (Occasionally, there will be a second morning weekend consultant)

# RMO shifts

- 07:00-17:00
- 12:00-22:00
- 14:00-midnight
- 22:00-08:00

- Handover will occur at 07:00, 16:00, and 23:30

# General Expectations

Be on time for your shift.

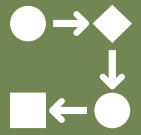
You will work the entirety of your 10 hour shift unless you fall ill.

If you must miss a shift due to illness, call and speak to someone in the ED. Do not call or leave a message with the MAU or with Rachel. Consultant phone: 027 442 4026

# General Expectations

Most of you will be slow and inefficient in the beginning.

We expect increasing knowledge and efficiency with time.



We also expect greater workload (seeing more patients) with time, but not at the expense of quality.

# General Expectations

- Breaks during your shift: 30 minutes
  - Stagger with your RMO colleagues
  - You must eat / take your break in the ED
- Timesheets are to be completed fortnightly in Rachel's office.
  - If you miss one, OK.
  - If you miss two, you will not get paid.

# General Expectations / Dress Code

- Consultants wear black scrubs (or at least a black scrub top).
- RMOs and MOSS wear grey scrubs.
- Medical students wear teal scrubs.
- Scrubs are found in the cabinet adjacent to the Paeds area.

# Computers

- Yes, we know we have a limited number.
- On these computers you will need to learn how to use the following programs:
  - Miya
    - Patient tracking
  - WebPAS
    - Where we write our notes and fill out ACC forms
  - Éclair
    - Labs and community dispensing
  - Regional Clinical Portal
    - Labs, medical imaging requests and results, discharge summaries, clinic letters
  - MidCentral email
  - Clinical resources
  - PACS
    - Where you can see images from DHBs in the lower North Island (Whanganui, Hawke's Bay, Capital & Coast, Wairarapa)

# The Roster

- RMO Rosters are written by the Medical Administration Unit with oversight by Dr Abdelhameed.
- Shift swaps-form must be completed in Rachel's office.
  - You may only swap with other RMOs of your level / experience.
  - Approval of shift swaps not guaranteed.
- Annual leave is coordinated by the MAU and Dr Abdelhameed.
  - Late requests will rarely be approved.

# Teaching

- SHO teaching is at 09:00 to13:00 every Thursday. Registrars required to stay for entire 4 hours. Non-training RMOs rostered to work in ED will attend only the 1st two hours.
- You are expected to attend each teaching session unless you are on leave or working nights.
- There will be opportunities for you to present a case / topic on one of our teaching days.

# Supervision

- RMOs are assessed by SMOs on a weekly basis.
  - You will receive feedback
- The mentor list will be posted in the department.
- You may arrange to meet with your mentor at any time during the quarter.
- Speak to your mentor about any audits you might want to do during your time in the ED.

# Triage

- Familiarise yourself with the Australasian Triage Scale (on the front of the ED nursing sheet).
  - 1 = immediately life threatening injury / illness
  - 2= must be seen within 10 minutes of arrival
  - 3= most patients. Might be sick. Might not.
  - 4= lower triage acuity but can still be complex
  - 5 = not at all life or limb threatening
- No cherry picking of patients.
  - If all patients waiting to be seen are of the same triage category, pick up the next one to be seen.
- ATS category 2 patients must be seen within 10 minutes of their arrival in the ED.

# Clinical Resources

- Document Management System (DMS)
  - Contains MidCentral clinical guidelines
- Up To Date
- TOXINZ
  - National toxicology resource
- New Zealand Formulary
  - National drug formulary
- Patient management plans
  - For frequent attendees and/or complex patients
- Textbooks

# Overnight

- There will usually be either a registrar, MOSS, or fellow house officer with more ED experience working with you.
- Speak immediately to your senior if you have a patient that requires an urgent CT or if you have a patient that is critically ill.
- The senior on at night will then call the consultant if necessary.
- The Associate Charge Nurse is also an excellent resource.

# Overnight

- There is a Trauma Team that functions 24/7.
- The overnight shift coordinator or ACN will put out a trauma call if criteria are met for Red or Yellow Trauma.
- The Medical Emergency Team do not come to the ED. All cardiac arrests are covered within the department, with assistance from the medical registrar if necessary.

# Post Emergency Department Assessment and Liaison (PEDAL) Team

- PEDAL nurse (Brenda Meads), social work, occupational therapy, physiotherapy
- PEDAL team work M-F 09:00-17:00
- Do not put old people in EDOA "for PEDAL" when you just don't know what to do with them.
  - Some may simply need to be referred for admission to hospital

# Emergency Department Observation Area (EDOA)

- For patients who will most likely be discharged home in < 24 hours. A few examples:
  - Patients who need to be observed after a head injury +/- awaiting head CT
  - Patients with renal colic who require CT KUB but initially present after hours
  - Patients who are pain free and awaiting a second troponin
  - Patients who may need to be assessed by the PEDAL team

# EDOA

- It is not a holding pen for specialty registrars.
- Other specialties / departments do not have access to EDOA.
- Do not put patients there because you are afraid to speak to the specialty registrar or because the registrar has refused to see the patient or has tried to bully you into putting the patient in EDOA until a time more convenient for that registrar.

# EDOA

When you put a patient in EDOA, you must write in your note a clear plan for that patient.

"EDOA" is not a plan.

For those patients spending the night in EDOA, you must chart their regular medications.

# Other important bits

- Deceased arrivals
- NZ Police
- Domestic violence / NAI
- Outpatient referrals
- Shorter Stays in the Emergency Department ("the 6 hour target")

# Deceased Arrivals

- You may be called upon to declare that someone is dead in the back of a hearse.
- You are to fill out only the Declaration of Life Extinct form.
- You are not to fill out / sign the death certificate.
- You are not to go to the morgue.

# NZ Police

- Do not give any verbal or written statement to police in the ED. When working in the ED, you are a representative of Te Whatu Ora and not a private citizen.
- Do not hand over / copy any medical records (including your ED note) if asked by a police officer in the ED.
- All requests for medical information or for police statements must go through the hospital Risk Management / Legal Department.
- There is a police statement template on all desktops.
  - You are being called upon as a witness of fact, not an expert witness. You are not to give any "expert" opinion unless you are forensically trained.

# NZ Police

- If the Police request medical information about a patient be given to them in the ED, they are to be reminded that there is a formal process to request patient information.
- If section 22C of the Health Act is invoked by the Police, please be aware that the Police are not empowered to demand information from any health care practitioner.
- If it is thought that releasing patient information is unethical, that information may be withheld at the discretion of the health care practitioner. Compelling immediate release of patient information requires either a search warrant or an order from the court.
- However, if it is thought that the immediate release of information to the Police is important to safeguard any person, information can be released at the discretion of the health care practitioner without the consent of the patient.
- We all want to be helpful, and we are built to trust people in official roles. However, we must always use good judgement and safeguard the privacy and dignity of our patients.

# Domestic Violence / NAI screening

- ALL children (< 16 years old) get orange NAI screen, regardless of reason for ED attendance.
- Do not forget to do domestic violence screening.
- Remember that New Zealand has some of the highest (if not the highest) rates in the OECD for child abuse, child sexual abuse, sexual assault, and domestic partner violence.

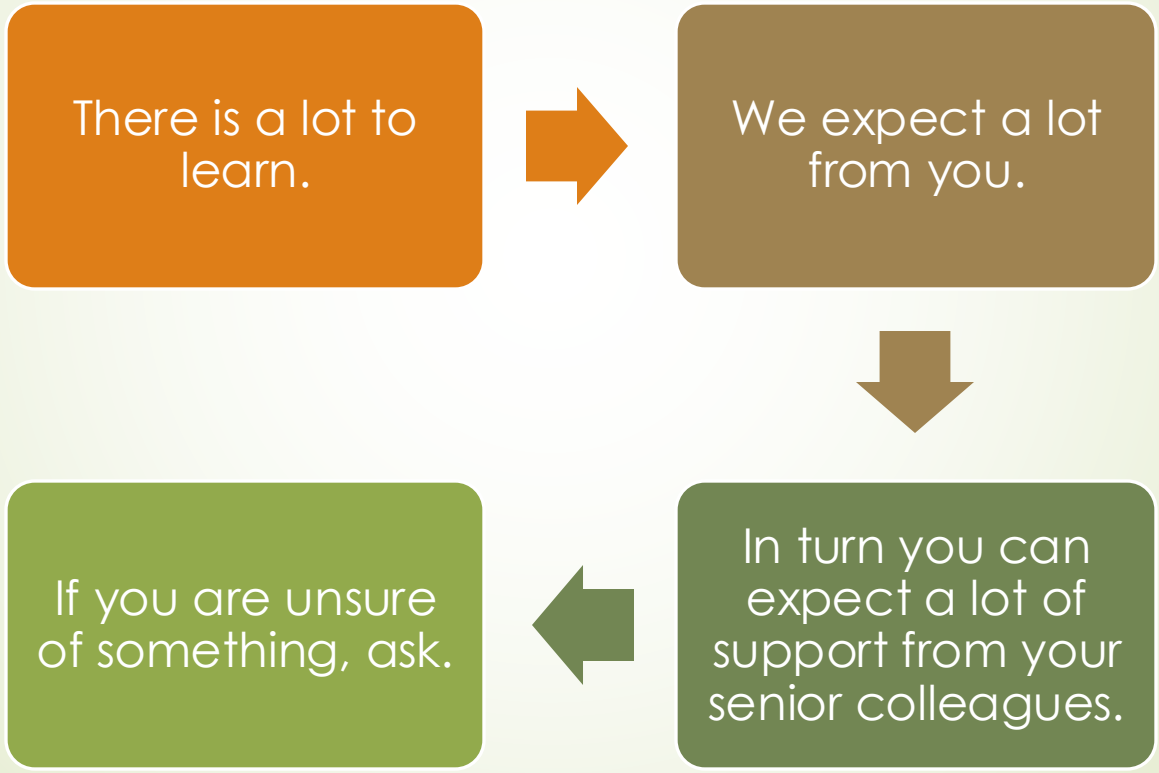
# Outpatient referrals

- Written on yellow form
- We do a limited number of these
- Must be of high quality
  - Why patient presented to ED
  - What was found in ED workup
  - Why the patient is being referred / Question(s) being asked of specialist

# SSED ("the 6 hour target")

- The goal is to move 95% of ED patients through the ED within 6 hours.
- This is a whole of hospital target, not an ED target.
- Often we are unable to reach this goal because the hospital is full and/or dysfunctional.
- It is important because inpatient morbidity and mortality markedly decline the closer we get to meeting the target.
- The Shorter Stays in ED target is changing, and will become a scale of targets for admitted and non-admitted patients.

# Summary


There is a lot to learn.
We expect a lot from you.
In turn you can expect a lot of support from your senior colleagues.
If you are unsure of something, ask.