EMERGENCY DEPARTMENT
JUNIOR MEDICAL OFFICERS'
HANDBOOK
2018

15. THE EMERGENCY DEPARTMENT

15.1 Introduction

The St Vincent's Hospital Emergency Department is a busy department treating approximately 42,000 patients each year. About 45-50 patients are admitted to the Hospital from the Emergency Department each day, a figure that represents some 50% of all hospital admissions.

Work in the Emergency Department is at times demanding and difficult. Patients come from all levels of society and present a wide spectrum of both medical and social problems. All actions and comments must be made with this in mind. All patients should be treated with dignity and respect. Because the Emergency Department is often crowded and busy, staff should be mindful that they need to protect patients' privacy and confidentiality at all times.

Despite these demands, work in the Emergency Department can be extremely fulfilling on a personal and a professional level. The courtesy and cooperation of all staff are essential to maintain the proper functioning of the Emergency Department.

15.2 Medical Staffing

Senior Staff

There is an Emergency Registrar on duty in the Emergency Department at all times. Staff Specialist cover is provided 7 days a week from 0800-2400. There is a Staff Specialist on call *at all times* should there be specific queries regarding patient care or administrative concerns.

Junior Staff

Junior Medical Staff in the Emergency Department are reportable to the most senior emergency medical staff member on duty at all times. This will usually be the Staff Specialist except for overnight on when they are off the floor, in which case it will be your team Registrar. It is expected that you will regularly update your senior regarding your patients. In particular staff should consult the senior emergency doctor about those patients who require admission *prior to* calling the inpatient team and before discharging anyone, and at any time when you have a question regarding their care such as the appropriateness of certain investigations or definitive management.

Sick Relief Roster

Please always be aware when you are rostered for Sick Relief. Ensure that you can be contacted at all times and provide additional contact numbers (mobiles, landlines, friend's mobile) for where you will be for the period you are on relief.

Calling in Sick

Ring the Emergency Department (the admitting phone: **0417 152781** or main department phone: **8382 3857**) and speak with the Consultant in charge of the shift in order for them to be aware and enable them to make appropriate arrangements with the JMO on for sick relief. Also contact the Clinical Superintendent's Office ph**: 8382 2563** to let them know. It is important that you speak with staff directly so that the message is received – ***Do not just leave a voicemail message***. After hours and on weekends, switchboard should also be notified. This is important so that relief can be called in a timely manner and shifts are covered adequately.

15.3 Ward rounds

Formal ward rounds take place three times per day at 0800, 1700 and 2300 hours. All emergency medical staff on duty must attend these rounds to present their patients. No emergency medical staff may leave the department until the patients have been adequately handed over and all relevant EDIS data completed.

15.4 Admitting Officer
The most senior emergency medical staff member on duty is also the Admitting Officer. *All calls from GPs, Consultants, Registrars or others referring patients to the Emergency Department should be directed to the Admitting Officer via the admitting phone (0417 152781)*. The Admitting Officer will enter the patient's details in the 'Patient Expects' screen on the EDIS system.

15.5 Geography of the Emergency Department

Acute Area
There are three resuscitation (R) bays and fifteen Acute (C) cubicles. All of these have cardiorespiratory monitoring facilities. There are also 2 isolation rooms (ISO), an Assessment room, a CIN Room and a Palliative Care Room.
The R bays are reserved for seriously ill and injured patients requiring continuous cardiorespiratory monitoring and close medical and nursing observation. The R bays are the responsibility of the senior emergency medical staff.
The remaining cubicles are reserved for less urgent patients. If there are any concerns regarding the patient's acuity or if procedures are performed which require closer cardiorespiratory monitoring, the patient can be moved to an R bay. These should be done in consultation with the Coordinating Nurse.

Fast Track Consultation Rooms
There are eight consultation rooms offering suturing, plastering, ENT and ophthalmologic facilities. For the optimum functioning of these rooms*, it is essential patients are not left in these rooms* if they are not undergoing specific interventions. Patients can be moved on to the Waiting Room, Fast Track Chairs or EMU after they have been seen (discuss with your senior if you are not sure where is most appropriate). All staff must clean up once the patient has vacated the cubicle in preparation for the next patient.

Fast Track Waiting Area
This area is located adjacent to EMU ward. It consists of 8 armchairs. The chairs are used to hold stable patients awaiting an inpatient bed or awaiting review prior to discharge. The area is open from 1000 to 1930 weekdays during which time nursing staff are allocated to the area. Each patient is entered into a log kept in the adjacent clerical area as well as on EDIS map. The patients' paperwork is stored in the nursing station. Only patients with low acuity should be placed in this area.

Seclusion Rooms (M1 and M2)
These rooms are located adjacent to R3. They are to be used for the assessment and observation of patients presenting with mental health complaints.

Ambulance Bay
Area designated for patients awaiting beds in the ED where initial assessment & treatment may commence.

Emergency Medicine Unit (EMU)
This is a short stay observation ward of the Emergency Department. It is a ten-bed ward and patients can only be admitted to EMU with the approval of the Emergency Staff Specialist on call. This unit provides an area for patients who need:

- short term observation period and/or investigation to determine their ensuing discharge or treatment
- short period of treatment but no formal in-patient care
- short admission for social reasons until proper arrangements can be made for safe discharge

It is expected that most patients will be discharged within 24 hours. However a small percentage may potentially require ongoing admission under an inpatient team.

PECC (Psychiatric Emergency Care Centre)
This is a 6 bed secure psychiatry ward in the Emergency Department, situated between the Consultation

Rooms and the EMU. It has its own dedicated nursing and medical staff and is used for short stay admission of patients with mental illness. PECC nursing and medical staff provide the Mental Health assessment service for all Emergency Department patients. Admission to PECC is controlled by strict criteria and potential admissions must be discussed with both the ED and Psychiatry consultant on duty.

15.6 Triage

An initial triage is performed by the Triage Nurse, an experienced Emergency Nurse. Triage is performed in association with the senior emergency medical staff when required. The triage process, based on the National Triage Scale, sorts patients into triage categories according to the acuity of their presenting problems. The patients' details are entered into the EDIS (Emergency Department Information System) computer. A list of patients is generated from which medical staff see patients.

Patients are seen firstly in order of triage category, then according to presentation time. This ensures that the more urgent cases are seen early and that patients are directed to an appropriate treatment area. If you are uncertain which patient should be seen next, please discuss with your senior. Remember to assign yourself to the patient on EDIS as soon as possible – this will help to ensure we meet our benchmarks in seeing patients.

Resuscitation	Immediate	1
Emergency	Within 10 minutes	2
Urgent	Within 30 minutes	3
Semi urgent	Within 1 hour	4
Non-urgent	Within 2 hours	5

15.7 Team based Medical care

As per the Models of Care the doctors operate as Teams.

- WHITE Team – In charge of Emergency patients & EMU patients; responsible for managing & discharging patients in ED from night shift. Fast Track patients will be seen & sorted by this team.
- RED Team – Manages patients admitted to Acute Area. Constitutes the BAT Team.
- BLUE Team – Commences later in the morning and assists in managing patients in Acute Area.
- GREY Team – Manages patients in the Acute Area until 5pm and thereafter all patients who present to ED.
- BLACK – Night medical team led by Emergency Registrar.

15.8 Special Patient Categories

Trauma Patients

In cases of trauma the senior emergency medical or nursing staff activate the group trauma page should specific trauma criteria be met.

There is a two-tiered paging system, comprised of stable and major trauma calls. The level of trauma call is determined by the senior medical officer on duty at that time and initiated by the nurse. Ideally it is

activated as early as possible to ensure the team is present prior to the patient's arrival. *All trauma patients presenting between midnight and 0800 hours are classified as major trauma.* Phone 555.

The trauma page is received by the:

- Surgical registrar of the day
- Anaesthetic registrar
- ITU registrar
- Blood bank
- Radiology
- Operating theatres

The surgical, anaesthetic and ITU registrars must all attend a Major Trauma call, regardless of time of day. "Trauma Alert" calls are attended by Emergency Department staff only.

If an Emergency Staff Specialist is present a "Trauma Alert" *may* be called if patient meets trauma criteria by mechanism ONLY and has NO Injuries or Signs of severe trauma.

Major Trauma - Mechanism:

- Fall > 3 metres
- Ejection from vehicle
- Death or severe injury to other occupants of the vehicle(s)
- Extrication time > 20 minutes
- MVA with vehicle rollover or significant damage to vehicle
- Medium to high speed MVA
- Pedestrian struck by motor vehicle
- Pedal cyclist struck by motor vehicle
- Fall from a moving horse
- Patient pregnant > 20 weeks
- Potential spinal injury (bony or cord)
- Consider patients >65 years with minor or moderate mechanism
- Inter-hospital trauma transfers within 24 hours of injury

Major Trauma Criteria – Injuries:

- Penetrating injury to any body region
- Flail chest
- Paralysis/ Sensory deficit/ Paraesthesia (Potential spinal injury)
- Pelvic instability
- Major crush injury or amputation of a limb
- 2 or more long bone fractures (except adjacent tib/fib or radius/ulna)
- Burns > 20%BSA in adults or >10%BSA in children
- Injuries to > 2 body regions
- Multiple injuries arriving simultaneously

Major Trauma Criteria – Signs:

- Airway problems including airway burns
- Cyanosis/capillary refill >2sec
- Systolic BP < 90mmHg
- PR < 50 or > 130 per minute
- GCS < 13
- Breathing difficulties /shallow breathing
- Respiratory rate < 10 or > 30 breaths per minute
- Intubated or attempted intubation

- Fitting
- Pupil(s) dilated or unreactive

Cardiac Arrests / Medical Emergencies
In cases of cardiac arrest or other acute medical emergencies staff *may* activate the group cardiac arrest page *should assistance be required*. It is not routinely activated.
Phone 555.
The cardiac arrest page is received by the following who must attend:

Medical registrar (cardiology registrar during the day)
Anaesthetic registrar
ITU registrar

The basic guidelines* for asking for assistance of senior Emergency Department staff include the following.

AIRWAY	Threatened
BREATHING	**All respiratory arrests** Respiratory rate < 5 Respiratory rate > 36
CIRCULATION	**All cardiac arrests** Pulse rate < 40 Pulse rate > 140 Systolic BP < 90
NEUROLOGY	Sudden fall in level of Consciousness (Fall in GCS of > 2 points) Repeated or prolonged seizures
OTHER	Any patient whom you are seriously worried about who does not fit the above criteria

Hand Injuries
Hand injuries are treated at the Hand Surgery Unit at Sydney Hospital. JMOs should consult with the senior doctor in the Emergency Department about any hand injury. All patients with complex hand injuries (fractures, nerve and tendon injuries) should be discussed with the Hand Unit registrar at Sydney Hospital (9382 7111) who will accept transfer of the patient for assessment or arrange for the patient to attend the next available Hand Clinic at Sydney Hospital.

15.9 Team Admissions
These are patients who would normally go through Admissions to a bed on the ward. They present to the Emergency Department, as there is no such bed yet available. During normal hours the inpatient team is notified and that team is responsible for that patient's admission process.
Included in team admissions are patients sent in from consultant's rooms and patients accepted by a

consultant from a GP and advised to present to the Emergency Department (unless the patient has a complaint unrelated to that consultant's area of expertise). After 1700 hours the patient is admitted by the Emergency Department staff.

15.10 Booked After Hours Admissions
Patients presenting to St Vincent's Hospital after 1700 hours and before 2100 hours and who have a bed available on the ward are admitted through the Emergency Department. A senior Emergency Department doctor assesses the patient's suitability for transfer to the ward. If deemed suitable, the patient is then transferred to the ward and admitted by the ward medical staff.

If the patient presents after 2100 hours or if the patient is deemed unsuitable for transfer to the ward, such as having ongoing chest pain or abnormal vital signs, the Emergency Department staff admits and manages the patient accordingly.

15.11 Patient Management
There are five components involved in managing a patient in the Emergency Department.

Assessment
This process includes determining the need for initial stabilisation of the patient prior to detailed history and examination. This includes assessment of airway, breathing and circulation and administration of analgesia. Always make the senior emergency staff aware of the state and progress of your patients.

Resuscitation
This may take place concurrently with Assessment.

Relevant investigations
Relevant investigations should be instigated promptly. Results should not necessarily be awaited before the decision to admit the patient is made. This should be discussed with the senior emergency doctor.

As a rule, no patient should be discharged prior to a result being known. This includes prior to transfer to the wards. Exceptions, such as microbiology or serology, should be followed up appropriately.

Definitive management
Admitted patients
Following a decision to admit a patient, the ED Navigator is informed. They are a senior member of ED Nursing Staff who is responsible for patient flow during the hours of 0800-1830. Outside these hours the ED Operational NUM should be consulted. The specific bed type required should be conveyed, e.g. acute coronary care bed, non-monitored general medical bed, EMU bed etc. An inpatient bed is requested and the clerical staff will process the admission. The patients will proceed to the appropriate area.

Should a patient be admitted, a senior member of the appropriate inpatient team should be contacted prior to the patient leaving the Emergency Department. Further care will be the responsibility of the Admitting Medical Officer (AMO) and team under whom the patient has been admitted.

As mentioned previously, all EMU patients must be accepted by the Emergency Staff Specialist on call.

Discharged patients
All patients should be discussed with the senior emergency doctor prior to discharge.
All patients discharged from the Emergency Department must be given a comprehensive letter, written in

and printed from EDIS, outlining the patient's course in the Emergency Department with relevant investigation results. The patient is advised to attend a GP, relevant specialist or outpatient department with the letter, who can then review the patient and the investigation results. Any results that are pending, such as microbiology, may be obtained by the GP.

If a Specialist has referred a patient to ED, they should be contacted and the patient's management **d**iscussed prior to patient discharge. Appropriate documentation should accompany the patient on discharge.

Patients should not, as a rule, be brought back to ED for follow-up. For continuity of care and optimal function of the Emergency Department patients are encouraged to attend a GP. If a patient has no GP, the patient should be strongly advised to obtain one. Failing this, for example in the case of overseas travellers, the patient may represent to the Emergency Department for follow up. The patient should be advised that no appointment times could be given, that waiting time cannot be guaranteed and that a different doctor may see the patient.

Safe discharge of the elderly should be considered in all patients over the age of 70 years. Involvement of the physiotherapist or social worker in ED may be useful in discharging the elderly. The patient's family should be contacted to ensure the home situation is satisfactory for discharge.

15.12 Outpatients (OPD)
The mainstay of patient follow up should be the patient's GP. However, the St Vincent's Hospital Outpatients Department (OPD) provides the Emergency Department with vital adjunctive services. Medical staff can make appointments on extension 23110.
If the patient is seen after hours, the patient can be given a referral letter with an outpatient referral form and asked to contact the OPD on Ph: 8382 3110.

Plastic Surgery Clinic
Injuries involving the face should be referred to the Plastics Clinic if inpatient treatment is not required. It is held every Monday morning. Old patients may be seen in a Thursday morning Clinic. *All patients should be discussed with the Plastic Surgery Registrar prior to the patient attending the Clinic.*

Fracture Clinic
Fractures and soft tissue injuries are followed up at the Fracture Clinic held on weekdays in the OPD.

HITH/HICLE
Patients should not routinely represent to the Emergency Department for review or changing of dressings. There is a daily wound review and treatment clinic in the OPD between 0800 and 0930. Dressings can be performed and parenteral medications can be given up to twice daily. If the wound needs review by a doctor, this should be stated clearly on the OPD referral form. Patients attending this clinic for parenteral antibiotics should be given the first dose in the Emergency Department and an outpatient medication form filled in and sent with their referral.

ENT Clinic
Clinics are held every Thursday and alternate Wednesday mornings. They are particularly busy clinics. Any patients deemed suitable for urgent follow up should be discussed with the ENT Registrar prior to an appointment being made.

Ophthalmology Clinic
Clinics are held every Monday and Thursday morning. As with ENT Clinics, they are particularly busy. Any patients deemed suitable for urgent follow up should be discussed with the Ophthalmology Registrar

prior to an appointment being made. The patient may be suitable for follow up at the Sydney Eye Hospital. This can also be discussed with the Ophthalmology Registrar.

Sexual Health
Follow up for sexual health problems is best coordinated through outpatient services such as provided at Sydney Hospital's Sexual Health Centre or Kirkton Road Clinic.

15.13 PEP (Post exposure prophylaxis)
A specific protocol exists for patients presenting *out of hours* post potential HIV exposure. It is available in the Emergency Department. Patients seen in the Emergency Department for potential HIV exposure are referred to the PEP clinic at St Vincent's Hospital. This is coordinated by the HIV Clinical Nurse Consultant. A 'PEP' folder is located in the Emergency Department that clearly explains the steps involved when treating a patient for PEP.
In hours, you can contact the PEP Clinical Nurse Consultant who may be able to see the patient.

15.14 Alcohol and Drug Service
The Alcohol and Drug Service provides counselling for outpatients during office hours in the O'Brien Centre. Inpatient referrals can be made during office hours to the appropriate Alcohol and Drug counsellor.

15.15 Investigations

Haematology, chemical pathology and microbiology.
Sydpath provides the pathology service to the Emergency Department. All pathology requests are made on Web de Lacy and samples are sent up to the lab via a chute in R2 along with a request form. Sydpath gives priority to all investigations requested by the Emergency Department. Should these investigations be required sooner Sydpath should be contacted on ext 29100 and the urgency of the test conveyed.

Patients are never given their results over the telephone.

Restrict investigations to those that will influence acute patient management.

Patients are strongly advised to present to their GPs who can obtain results directly from Sydpath.

Medical Imaging
All Medical imaging requests are made online on Web de Lacy.
Ultrasound booking confirmation can be made on ext 22144.
CT scan booking confirmation can be made on ext 23495.
Approval for CT scans and ultrasound can be made via the radiology registrar.

Medical Imaging Requests must be correctly completed online, including:

- Patient MRN
- Patient Location in the Ward/Clinic Section (eg. FT, C3 or R1)
- Transport / Monitoring or Escort Requirements
- Your Name and electronic signature
- Examination Requested
- Relevant Clinical History and Information sought.
- Reference to contrast allergies or pregnancy.
- Document the patient's current Creatinine level for contrast examinations.

Please be reminded that this is a legal document.

Hard copy films are not provided to the Emergency Department. All images must be viewed on the dedicated computed viewing station.

For CT / Ultrasound / Magnetic Resonance Imaging examinations contact the Radiology Liason Doctor (RLD) on 21860 or 0436 659170 after discussion with the ED senior doctor.
If you discharge a patient for review by their GP, please give them a letter outlining the test results that need to be chased. This will enable to GP to access the formal radiological result without difficulty.

Blood alcohol testing
It is a legal requirement that blood be taken for a 'police' blood alcohol sample from a patient involved in a motor vehicle crash. This includes drivers / riders of motor vehicles, pedestrians and patients on non-motorised vehicles. This investigation should not take priority over patient care.

If a patient refuses to have a sample taken, the patient should be advised that he or she is breaking the law. The patient should not be forced or threatened into giving a sample. All details should be carefully documented in the notes.
It is essential the appropriate kit, including the alcohol-free swab provided, be used. The samples should be fixed with the appropriate label. The sample is placed in the Police Box in the Write-up Room.

HIV
HIV positive patients are commonly referred to as 'Immunology B' patients at St Vincent's Hospital. Unless a patient's HIV status is important to the management of that patient's acute condition, routine HIV screening should not be done in the ED. Patients should be referred to their GP or to an appropriate clinic (e.g., Albion St, Immunology B) where testing can be carried out in an unhurried manner with appropriate pre-test counselling. Patients should never return to the ED for the collection of HIV results. The result should be sent to their GP or to the Immunology B clinic where they can be given the result.

Other
Results of other investigations such as ECGs or medical imaging when no report is available should be discussed with senior emergency medical staff.

All ECGs performed in the Emergency Department must be shown to a senior doctor & signed by that doctor.

15.16 Prescribing
Patients are encouraged to have prescriptions filled by community pharmacies. If appropriate, patients may obtain medications from the Hospital Pharmacy during 1000 – 1700 hours weekdays. St Vincent's Hospital Pharmacy scripts must have the patient's MRN at the top. On nights and weekends, patients may be given starting doses of commonly used drugs from the after-hours drug cupboard in the Emergency Department. These drugs must have the label completed by a member of the Emergency Department medical staff. A script must be left to cover the drugs issued. Alternatively a script can be written for an outside pharmacy. Such prescriptions must conform to the requirements of the Pharmaceutical Benefits regulations.

15.17 Medical Records & Documentation
These are the records of a patient's attendance and as such are important medical & legal document. It is essential that medical records be completed accurately with the following information:

- Date, time and printed name of the Medical Officer
- A short succinct history and examination
- Results of investigations
- A final or provisional diagnosis.
- Management Plan or Patient disposition

- A signature
- Medication Charts should be written for each patient.

The triage sheet is used to document brief presentations only. Progress notes should be used for documentation of complex histories/ likely admissions – these can be handwritten or typed on EDIS as a Clinical Note. If you write your notes on EDIS please do not forget to print them out and place them in the patient's file.
Each patient's notes along with patient's old notes and relevant investigation results should at all times be kept together in the appropriate storage area corresponding to that patient's bed.

Patient's old notes are automatically called for every patient presenting to the Emergency Department. They are brought into the clinical area by the clerical staff. The clerical staff should be contacted on ext 22520 if these are not available.

15.18 Adjunctive Emergency Department Services

Social Work
A full-time Social Worker is available within the Department between the hours of 0830 and 1700 every day.
The Social Worker on for the day, along with their pager number, is updated daily on the white board outside the resuscitation room.
Examples of patients who should be referred to the Social Worker are those

- not coping at home
- needing assistance with mobilising community supports
- needing assistance with alternative placements, such as nursing home, private hospital
- having difficulties with finance, accommodation or employment
- with bereavement, especially sudden death, SIDS, trauma
- marriage or relationship difficulties
- children at risk
- victims of domestic violence
- victims of crime

The Social Worker should be present at the morning ward round to either be referred patients or to update the medical and nursing staff where appropriate.

Mental Health Service
A 24 hour mental health service exists for help in the assessment and treatment of acute psychiatric problems. This service provides all information regarding the Mental Health Act and its application in the Emergency Department. The service should be consulted for all patients with a mental health problem as a major factor in their presentation.

All mental health patients, except for Section 22 patients brought in by the Police, should be seen initially by an Emergency Department doctor who will perform an appropriate medical assessment and then initiate contact with the Mental Health Service by contacting the PECC doctor. Each day until midnight, Section 22 patients will be fully assessed by members of the psychiatry team. Outside of these hours, these patients will need to be assessed by Emergency staff.

Physiotherapist
A full time physiotherapist is based in the Emergency Department from Monday to Sunday from 0800 to 1630 (pager number 6234)
Patients who should be referred to the physiotherapist include

- those with acute respiratory conditions (exacerbations of CAL / pneumonia)

- those with musculoskeletal conditions (eg acute lower back pain, ankle sprains and whiplash patients)
- those for mobility assessments
- those who need assistance with discharge planning

A physiotherapist will be present at the 0800 ward round to take referrals for the service and update medical staff as appropriate.

Alcohol and Drug Counsellor
A counsellor is available on weekdays from 0800h to 1630h for all patients presenting with an alcohol or drug problem, or patients who may incidentally have such a problem (pager number 6181).
When a counsellor is unavailable, they should be referred to the social worker and/or given an Alcohol and Drug Information Service (ADIS) card, available at triage.

Hospital in the Home (HITH)
They should be referred any patients from the Eastern Suburbs who are to be discharged and who may require ongoing antibiotics intravenously, most commonly for cellulitis.
If outpatient medications are to be given, these must be written up on a hospital medication chart. First dose of antibiotics must be given prior to discharge. Referrals need to be made via WebDelacy and contacting the HITH CNC.

Victims of Crime
The Department has a protocol in effect for patients and their relatives who are victims of crime. It is important to refer to this policy when a need for assistance arises.

Victims of Sexual Assault
Victims of sexual assault are referred to Royal Prince Alfred Hospital Sexual Assault Service. The patient should be discussed with the service at RPAH prior to referral.

Interpreter Service
An interpreter service is available at all times. This service is available over the phone or face-to-face. This service should be used as the first line for non-English speaking patients. The use of patient relatives or friends, medical or nursing staff or other hospital staff to translate is actively discouraged.

15.19 Ambulance Notification
RED PHONE
The RED PHONE/COMMUNICATIONS RADIO (Direct Line from Ambulance Control Centre) must be answered immediately by the most senior member of the emergency department staff. It is rung when there is a patient en route to the Emergency Department via ambulance who requires or may require advanced resuscitation.

- The mnemonic 'MIST' should be used to ensure adequate transfer of information.
- M mechanism of injury
- I injuries sustained
- S vital signs
- T treatment given
- time of expected arrival

Code Brown: In the eventuality of an alert of disaster occurring each member of staff in the ED will be given a task card, which will outline their responsibilities.

15.20 Other Administrative Procedures
Worker's Compensation Cases
Accurate documentation in the patient's notes is required, as many of these patients will be involved in

litigation. All but the most trivial injuries should be referred for follow-up, either to the appropriate specialist, LMO or hospital clinic, e.g. Plastics or Fracture Clinic. All patients must be given the appropriate form to take back to their employer.

Medical Certificates
Certificates may be written for a maximum of 5 days at a time after which time the patient should have a medical review, e.g. by GP. *Work certificates must not be given retrospectively***.**

Dead on Arrival in the Emergency Department (DOA)
In the event of an ambulance bringing a patient who is dead on arrival to the Hospital, a medical officer from the Emergency Department certifies the body as being dead and registers the certification by filling in a DOA form (kept in the ED clerical area). The police should be summoned to take custody of valuables and the Government Funeral Contractor notified to collect the body immediately.

15.21 Children
Children should be triaged as category 1 or 2. They should be seen in consultation with or by the most senior member of the emergency medicine staff. Minor problems should be treated as necessary but where the child requires investigation or management a transfer to a Children's Hospital (usually either Sydney Children's or Royal Prince Alfred Hospital) should be arranged as soon as possible. The destination hospital should be made aware of the transfer. Appropriate transport and escort resources should be discussed with the destination hospital.

15.22 Infection Control Precautions
All staff should be immunised against Hepatitis B, tetanus and covered for TB.
There is a staff member available through outpatients (ext. 23131) to facilitate immunisations.

Universal precautions should always be practiced. All patients should be considered potentially infectious.

Sharps
Take particular care with sharps.
Never resheath needles.
Always use the 'Vacutainer' system.
Always clean up after yourself following a procedure involving sharps, e.g. suturing, lumbar puncture, and central line insertion.

Protective clothing
Protective clothing should be worn where there is a risk of body fluid exposure, i.e. gloves, facemask with visor or goggles, impervious gown.

Body fluid exposure
St Vincent's Hospital has in place a protocol should a body fluid exposure occur. All staff should be familiar with this.

Hand Hygiene
Don't forget to adhere to the 5 Moments of Hand Hygiene at all times. It is acceptable to use Alcohol Based Hand Rub unless hands are visibly dirty or you have seen a patient with possible C. difficile or Norovirus infection, in which case hand washing with soap and water is required. A number of ED staff are auditors and will be watching you!

15.23 EDIS SYSTEM

The EDIS system assists in prioritising patients, locating patients, recording who is attending them, what their diagnoses are and what their disposition may be. It is also an important research tool. The importance of accurate completion of relevant patient data and maintenance of patient confidentiality by the emergency medical staff cannot be stressed enough.

15.24 Education

There are regular teaching sessions & tutorials for JMOs from Monday to Friday from 1530 to 1600 hours in the write-up room (Medical Staff Room) next to the Clerical Office. All JMOs rostered on duty at that time should attend the tutorials. Any urgent patient care matters should be handed over to the Registrar on duty to allow the JMO to attend the tutorial.

CPR

Each medical officer will be trained and assessed in CPR as part of the hospital wide policy of accrediting all medical staff annually in CPR.

15.25 Transfer of Critically Ill Patients from St. Vincent's Hospital Emergency Department to other Hospitals

INTENSIVE CARE BEDS

Patients are usually transferred from the Emergency Department due to lack of ICU beds at St Vincent's Hospital. There are occasions when patients require specialised treatment not available at St Vincent's Hospital, such as hyperbaric therapy, spinal unit care, burns care and liver transplant care.

SPECIALTY UNITS

At the moment there is no central number for finding speciality beds such as burns and spinal unit beds. Individual units need to be contacted directly. The Registrar of the Unit should be spoken to first.

TRANSFER PROCEDURE

- Decision to transfer made.
- Organise bed at receiving hospital.

A central phone number can be rung at the NSW Ambulance Medical Retrieval Unit (MRU). This number is staffed 24 hours/day. The MRU will take on the responsibility of finding a bed.

This number is 1800 650 004

15.26 Contact Details

A daily roster of all St Vincent's Hospital Senior Medical Staff is available at the staff base, at triage and on the intranet. Included in this is the name of the Emergency Physician on call for that day. If there is no Emergency Physician in the Emergency Department, the Emergency Physician of the day should be contacted by the Emergency Department registrar should there be any concerns regarding patient care or administrative functions.

Medical

Acting Director	A/Prof Paul Preisz	0404 860 796
Staff Specialist	Dr John Raftos	0402 114 906
Staff Specialist	Dr Judy Alford	0421 998 369
Staff Specialist	Dr Iromi Samarasinghe	0417 492 233
Staff Specialist	Dr Fiona Chow	0419 600 623
Staff Specialist	Dr Julie Leung	0412 300 621
Staff Specialist	Dr Kevin Maruno	0447 245 573
Staff Specialist	Dr Monique Cruz	0413 584 406
Staff Specialist	Dr Melinda Berry	0410 987 301
Staff Specialist	Dr Nikki Woods	0411 186 665
Staff Specialist	Dr Jessica Green	0413 390 109
Staff Specialist	Dr Gonzalo Aguirrebarrena	0425 816 288
Staff Specialist	Dr Rahul Santram	0405 546 489

Nursing

Nurse Manager	Mel Kelly	page 6110
Clinical Nurse Consultant	Julie Gawthorne	page 6402
Clinical Nurse Educator	Beth McAlary	page 6314

ALLERGIC REACTIONS: 3 STEP MANAGEMENT

ANAPHYLAXIS

skin **AND** gastro or cardiovascular or respiratory involvement

CARDIOVASCULAR
hypotension
collapse
arrest

RESPIRATORY
throat/chest tightness
stridor/wheeze
resp. distress

GASTRO
nausea
abdo pain
vomiting

ADRENALINE
0.01mg/kg IM lateral thigh

max 0.5mg = 0.5mL 1/1000 adrenaline

monitor vital signs
high flow oxygen
IV fluid bolus: 0.9% sodium chloride 20mL/kg
supine position
review in 3-5 mins

HYPERSENSITIVITY
skin involvement only

urticaria or erythema

angioedema or periorbital swelling

Loratadine 10mg PO

GASTRO OR CARDIOVASCULAR OR RESPIRATORY FEATURES EVOLVE

ANAPHYLAXIS PERSISTS: give more adrenaline and…

CARDIOVASCULAR

IV fluid bolus: 0.9% sodium chloride 20mL/kg

consider…
adrenaline infusion
metaraminol,
atropine,
noradrenaline

RESPIRATORY

salbutamol neb
and
hydrocortisone 100mg IV QID

consider…
adrenaline neb

ANAPHYLAXIS RESOLVES: observe for 4 - 6 hours and…

arrange an Epipen: requires authority script from GP

if hydrocortisone started: prednisone 1 mg/kg (max 50mg) daily for 4 days

give action plan and allergen exposure info:
www.allergy.org.au/anaphylaxis/index.htm

arrange allergy clinic appointment
8382 3150

Emergency Department, St Vincent's Hospital, Sydney, 2006

Based on: Brown S. Anaphylaxis: clinical concepts and research priorities. *Emerg Med Aust* 2006; 18: 155-169

Emergency Process for Mental Health Presentations

Patient Presentation	Triage	Management Plan	Assessment Process
WALK INS	TRIAGE	CHECK FOR MANAGEMENT PLAN#	MEDICAL ASSESSMENT BY ED^ REFER TO PECC FOR MH ASSESSMENT
AMBULANCE	TRIAGE	CHECK FOR MANAGEMENT PLAN #	MEDICAL ASSESSMENT BY ED^ REFER TO PECC FOR MH ASSESSMENT
AMBULANCE Section 20	TRIAGE	CHECK FOR MANAGEMENT PLAN #	MENTAL HEALTH AND MEDICAL ASSESSMENT BY PECC
POLICE Section 22	TRIAGE	CHECK FOR MANAGEMENT PLAN #	MENTAL HEALTH AND MEDICAL ASSESSMENT BY PECC
COMMUNITY MENTAL HEALTH TEAM (Involuntary under Sch. 1)	TRIAGE	CHECK FOR MANAGEMENT PLAN #	MENTAL HEALTH R/V AND MEDICAL ASSESSMENT BY PECC
TRANSFER FROM OTHER WARD/HOSPITAL	TRIAGE	CHECK FOR MANAGEMENT PLAN #	MENTAL HEALTH R/V BY PECC

[redacted]

1. Check EDIS Alerts if pt has Management Plan
2. Management Plans can be accessed by Snr Medical/Nursing staff via Mediweb

[redacted]

1. Medical Assessment & Medical Treatment
2. RAPID Assessment

For PECC Liaison Nurse please page 6024

Acknowledgement to Sarah Horrobin PECC CNS in the development of this flow chart

Rapid Assessment of Patients In Distress

St Vincent's Hospital
Charity, Care & Compassion

MRN	SURNAME		
OTHER NAMES			
DOB	SEX	AMO	WARD/CLINIC

COMMENTARY

These questions are to assist your assessment of patients with potential mental health problems

Is the patient too sedated or disorientated to give a meaningful history?

First ensure your safety and other; does the patient have a weapon?
IF YOU SUSPECT THE PATIENT HAS A WEAPON, SUSPEND THE INTERVIEW NOW, CONTINUE WHEN SECURITY HAVE IT IN CUSTODY

Points to consider:
* Risk to self or others, urgency of referral and initial management plan
* These problems may require involuntary assessment to prevent inappropriate discharge, if so, institute safety and security procedures NOW

Predictors of violence include: History of impulsivity and violence; drug and alcohol use; antisocial personality

Degree of Risk is crucial in deciding the urgency of mental health intervention and response

Start a problem list: think broadly about the patient's medical, social and mental health needs. The Social Worker/Psych CNC help gather information

WHAT IS THE PROBLEM?*

❑ Suicidal Ideation*	❑ Depressed	❑ Anxiety/Panic	❑ Stress
❑ D & A Withdrawal*	❑ Thought Disorder	❑ Hallucinating	❑ Delusional
❑ Bizarre Behaviour*	❑ Aggression*	❑ Agitation*	❑ Intoxication*

WHAT DOES THE PATIENT WANT?

❑ Psychiatric Treatment (in or out patient?)	❑ Medication	❑ Someone to talk to?
❑ Accommodation	❑ Detox	❑ They don't know

CAN I GET AN ADEQUATE HISTORY NOW? ❑ YES ❑ NO

WHERE CAN I GET INFORMATION FROM?
Community Mental Health Team? GP? Family or Friends? Case Manager, Psychiatrist, Psychologist or Counsellor? Non Government Agency (NGO)?
Is anyone else with them or in the waiting room?
Do you live with anyone? ❑ YES ❑ NO Does the patient have any children? ❑ YES ❑ NO
If so, where are those children now (note details)

CURRENT MEDICATIONS? (PROVIDE DETAILS)
Complete a physical examination and relevant investigations
Pulse: BP: / RR: Temp: O_2 Sat: BSL:
Neck Stiffness, Photophobia, Kernig's Sign, Skin Rash
CNS:
CVS:
Respiratory:
Abdomen/GIT:
Bloods:
Send blood in Purple, Blue and Green top tubes & Urine sample
Order FBC, EUC, BSL, Paracetamol & BAL
Consider (and order as indicated) additional tests such as Coags, LFT, βHCG., others as indicated by clinical assessment for organic illness
Additional tests (such as Syphilis serology) will be ordered by the inpatient team as add-on tests from the blood already taken on presentation and held in the lab
Urine: Urine Drug Screen, Urinalysis, Culture and Sensitivity, Microscopy
Imaging: CXR, ECG, CT (as indicated)

HAVE YOU THOUGHT LIFE ISN'T WORTH LIVING?	❑ YES	❑ NO
HAVE YOU THOUGHT OF HARMING YOURSELF?	❑ YES	❑ NO
ARE YOU THINKING OF SUICIDE?	❑ YES	❑ NO
Have you thought about how you would do it? (Details)	❑ YES	❑ NO
How often are you having these thoughts?		
Have you tried to harm yourself in the past?	❑ YES	❑ NO

If yes, how many times over what period?
❑ past 24 hours ❑ past week ❑ past month ❑ longer (Details)

Do you have ready access to the means of self harm?
Do you plan to do this? And when?
If suicide attempt has been made....

Do you still have access to the method used?	❑ YES	❑ NO
Do you have easy access to a weapon, especially firearms?	❑ YES	❑ NO

Establish current location
HAVE YOU THOUGHT OF HURTING ANYONE ELSE? IF YES, & SAFE TO PROCEED.....

Have you acted on these thoughts?	❑ YES	❑ NO
Have you been involved in fights recently?	❑ YES	❑ NO
If yes, were you using drugs or alcohol at the time?	❑ YES	❑ NO
Have you ever been charged for assault?	❑ YES	❑ NO

Wilhelm, Kotze, Ballard and Hudson. Consultation Liaison Psychiatry & Emergency Department, St Vincent's Hospital, Sydney 2010. Created 2001 (Revised Hudson & Gregory, 2005) (2nd Revision Wilhelm & Preisz, 2007)

DOA = DEAD ON ARRIVAL
(via Government Contractor)

This is a deceased person coming to ED via Government Contractor to be pronounced "Life Extinct" before proceeding to Glebe Morgue.

<u>This is a legal document</u>

Admin alerts doctor there is a DOA to certify (please do not receive a DOA directly from the Contractor, Admin staff need to process the details first)

Doctor examines body in ambulance bay

Doctor signs form for Government Contractor

Doctor returns to Reception to "sign off" DOA as follows:

On the back of the "ED Registration Form" the doctor should write the details of the physical examination of the DOA. The doctor should then sign and PRINT his/her name next to the signature and include the date and time for hospital records.

<u>Return the Registration Card to the Admin Officer in Reception,</u> please do not leave it in the filing box or elsewhere to be mislaid. This paperwork is filed separate from Medical Records.

NO details are required to be entered onto any hospital applications (EDIS) by medical staff, this will be done by Admin.

Thank you
A/Professor Gordian Fulde Trish Hendry