INTRODUCTION:

Welcome to the Nelson Hospital Emergency Department, (ED). The ED sees approximately 26,000 patients per annum and has an admission rate of approximately 25%. Nelson Hospital serves a wide catchment area at the top of the South Island and you can expect to see and manage patients that cross all the major disciplines. As a regional hospital we do not staff all subspecialties and from time to time patients will be retrieved to larger tertiary institutions or more specialised facilities (e.g. Burwood spinal unit, Wellington Hospital neurosurgical unit, Hutt Hospital plastics and maxillofacial service).

Nelson ED applies the Australasian triage scale (ATS), which is used in all Emergency Departments in Australasia. You will join a cohesive team of Emergency Specialists, experienced senior medical officers (SMO’s) and emergency nurses. It is anticipated you will work hard during your rotation to the Emergency Medicine, but will undoubtedly gain in confidence and experience.

STAFF:

- Clinical Director - Dr Tom Morton (FACEM)
- Clinical Leader & St Johns Liaison - Dr Chris Abbott (FACEM)
- Senior Medical Officers
  - Dr Andrew Munro (FACEM)
  - Dr Tom Jerram (FACEM)
  - Dr Alex Browne (FACEM)
  - Dr Clive Garlick
  - Dr Fran Halfdor
  - Dr Kanishka Jayasena
  - Dr Mark Reeves

- Clinical Nurse Leader - Jan Mitchell

FACILITY:
The ED is part of the hot floor concept and is immediately adjacent to radiology, Intensive Care and the operating theatres. A tour of the facility will be arranged. Please feel free to utilise the staff tea room, change room and toilet and shower facilities at any time. Please respect patient privacy and maintain professional standards at all times, particularly when working at the staff station.

MAIL:

ED SHO’s will have access to the Hospital Intranet. Letters and important documents may also be placed in the shared house surgeon pigeonhole in the ED staff office or in the house surgeon quarters.

MEALS:

Nelson Marlborough District Health Board supplies ED SHO’s with meals during the evening and out of hours. Note that an evening meal must be requested from the kitchen before 4.30pm. Please liaise with the ED senior doctor on the floor with you regarding the timing of any breaks.

ROSTER:

Six ED SHO’s rotate through a revolving roster. This was designed by the house surgeon RDA rep, and has been approved by the RDA. The nature of the Emergency Department work demands relatively frequent exposure to evening shifts and night shifts, however this is generally compensated by a shift duration of only eight hours, and days off subsequently. Lengths of night runs have been kept to a minimum to aid recovery and according to accepted best practice. One week on the roster is designed as a relief week so leave can be covered internally where ever possible. The ED SHO roster is administered by the RMO co-ordinator (Loretta Matheson).

LEAVE:

Leave requests should be filed with the RMO co-ordinator in the first instance. If at all possible leave during rotation onto nights should be avoided. In the event that more than one house surgeon is away on leave, there is an understanding that a person from the general pool can assist in covering leave for Emergency Department SHO’s. Please notify the RMO co-ordinator ASAP in the event of sickness and additionally call the senior ED doctor on duty to notify them of your absence.
**WORK LOAD:**

Case mix in the Emergency Department is by nature extremely varied. The ED SHO is expected to ensure that patients are seen in a timely fashion and to maintain patient flow through the Department. Between 8am and midnight a Senior Medical Officer or Emergency Specialist will be on duty for consultation, however they may become involved with issues that the house officer is not aware of, for example a violent or difficult patient, patient complaints, administrative tasks etc. Generally the SHO is well supported by the ED SMO or inpatient specialists.

**TRIAGE TIMES AND ED LENGTH OF STAY**

The ED has to meet requirements set by the Ministry of Health. This includes the number of patients who are not seen within their prescribed triage times (Cat 1 – immed, Cat 2 – 10 mins, Cat 3 – 30 mins, Cat 4 – 60 mins, Cat 5 – 120 mins). A high level of awareness of patients entering the department is asked for, and it is expected that you will endeavour to see patients as soon as possible. Please do not continue writing notes when a triage 2 patient is brought into the ED – and be aware that some administrative time will have elapsed before the notes arrive. You do not need notes to clinically assess patients – also make sure that you accurately enter times into the box on the ED Medical Record (the clock “stops” when an ECG is sited for a chest pain patient, or when a patient is sent to x-ray from triage and there are a number of other pathways that we use – please ask).

The ED also has to meet a length of stay target of less than 6 hours. It is imperative that you are aware of any patients spending a long time in the ED and ensure that these patients are referred or discharged in a timely manner. This is regularly audited.

**HOUSEKEEPING TASKS:**

Each day the SHO on duty is required to check and sign laboratory and x-ray results and reports. Significant abnormal results should be correlated with the patient’s clinical record, and any discrepancy alerted, documented and the patient notified with appropriate follow up arranged. Any concerns should be discussed with the ED SMO on duty.

**SHIFT WORK:**
The nature of shift work may be new to some SHO's. Do not underestimate the impact of sequential evening or night shifts. Many house officers find this more tiring than they would expect. Strategies and information for coping with this are available from Dr Chris Abbott.

**HANDOVER:**

Handover occurs at the change of each shift, i.e. at 8 a.m., 4pm and 11.00 pm. Generally there is an overlap period of about half an hour where cases are handed over. As a general rule SHO’s should handover to the incoming senior doctor using a team approach at the white board. Where possible SHO’s should finish managing the patients they are dealing with prior to leaving the department as this is more satisfying. However it is recognised those awaiting x-rays, some laboratory results or requiring further observation will need to be handed over. Document when and to whom a patient has been handed over.

**RESUSCITATION:**

ED SHO’s are encouraged to become actively involved with any resuscitation occurring in the Department. ED SHO’s are encouraged to familiarise with the resus set up and with the NZRC Level 7 Resus Manual.

**RESUSCITATION TRAINING:**

House Officers at Nelson Hospital are required to attend a NZ Resuscitation Council level 7 Course. Contact: Dr Chris Abbott who is the resus co-ordinator to arrange this. Other opportunities for resuscitation training occur during the Emergency Department CME session on Tuesdays. In addition Dr Mark Reeves will be offering directed learning opportunities in this area throughout the year.

**ED CME:**

The Department has its own CME session from 8.30 to 10.00 each Tuesday. All ED SHO’s are strongly encouraged to attend. This session takes the format of an x-ray case review session, and a seminar or case presentation in alternate weeks. At times SHO’s may be asked to help contribute to their meetings. Other CME meetings occur at lunch times for hospital house surgeons and the ED house surgeons are able to attend these, depending on circumstances in the Emergency Department at the time.

**GUIDELINES AND RESOURCES:**
Many guidelines and protocols are available on the hospital Intranet. Hard copies can be found in folders at the staff station. The Emergency Department has its own Intranet site which contains guidelines on flow plans, trauma, disasters, hazardous material etc. The Department of Medicine has an Intranet site which contains protocols for the management of common medical conditions. A wide variety of current Emergency textbooks and journals are available in the library at the staff station.

**INTERACTION WITH GP’S:**

The Emergency Department plays an important role at the interface between the community and the hospital. GP’s referring patients in are to be spoken to with respect, and the patient details including name, date of birth and hospital number clearly recorded. If a GP phones with a patient who clearly requires admission to hospital they can be politely diverted to the appropriate inpatient admitting house surgeon, so as to expedite management of the patient by the appropriate team on arrival.

All patients who are discharged must have an electronic discharge completed and a copy printed for the file. Ideally an e-summary should be done for all admitted patients as well, but this is currently not mandatory. Do not write both a hard and electronic copy – this is not good use of your time. Please continue to record time seen and discharged as well as final diagnosis on the patients red Front Sheet.

**REFERRAL TO OTHER TEAMS:**

Patients with problems that clearly require admission under an inpatient team can be referred by SHO’s directly to that team. If any doubt arises over the appropriate disposition of a patient the case should be discussed with the ED SMO. It is not absolutely essential to have a definitive diagnosis before a referral is made if it seems likely that the patient will require admission. When referring to specialists, ensure that you state clearly; your intention to admit the patient, or to ask for advice, and state the patient’s name, age and their major problem at the beginning of the referral.

**REFERRAL TO OUTPATIENTS:**

As a general rule referrals to outpatients from the Emergency Department should be kept to a minimum. If possible patients should be referred back to their general practitioners. If it seems appropriate for a patient to be seen in an outpatients clinic ensure sure that you discuss this with a senior Emergency Department doctor on duty or relevant specialist prior to placing a referral in the mail. Note that pathways exist to have eye FB patients followed up by an Ophthalmologist in their rooms. This is likely to be extended to other patient groups. Please ask an ED senior if you wish to bring a patient back to ED for a review.
**FRACTURE CLINIC:**

Most patients seen with a significant fracture in the department should be followed up in the fracture clinic. Fracture management guidelines, including appropriate referral channels are kept on the intranet and next to the x-ray viewing screen.

**DOCUMENTATION:**

It is important to write brief but concise notes. It is essential to include the main presenting complaints, focused examination findings, your impression and plan with particular attention to times seen and discharged, allergies and tetanus status, any drugs administered and follow up arrangements. Specific forms are provided for the assessment of trauma, burns and spinal injuries. See above for information on the electronic discharge. It is not essential for the Emergency Department House Surgeon to clerk a patient being admitted to hospital. If this can be done efficiently and quickly, (particularly when the department is quiet) then this is recommended. However during peak periods incoming emergency patients take priority.

**COPING WITH BUSY PERIODS:**

There are peaks and troughs in Emergency Department attendance. During peak periods additional resources may be required. A guideline is available for management of Emergency Department overload and this is available in the triage office, the guidelines folder and the disaster cupboard in the staff office. If you ever feel the workload is becoming unmanageable in the department speak directly with the co-ordinating nurse and the senior ED doctor on duty.

**ACC FORMS:**

It is essential that all patients involved in an accident have an ACC45 form completed, including details of the injury, an injury code (READ code), relevant other referrals, for example physio; relevant time off work etc. Attention to this saves an enormous amount of clerical work.

**ASSESSMENT:**
The intern supervisor requires us to complete a form on each SHO at the end of the attachment and we try to discuss this with each doctor. Each of you will be provided with an SMO mentor, and it is expected that you will meet together at least twice during your rotation.

**NURSING STAFF:**

The Department is well resourced with extremely experienced emergency nurses. Please listen carefully to them and respect their judgement. In many situations they will be accustomed to dealing with a patient with a particular problem and will be able to advise you on an appropriate line of treatment and follow up. All nurses in the Department are capable of IV cannulation, blood taking, performing ECG’s, dressings, plasters etc. However SHO’s are encouraged to perform as many of these tasks themselves as possible for their own learning purposes and experience. SHOs are also expected to do these tasks when the nurses are busy with other responsibilities. Please be respectful and polite when asking nurses to assist you with a patient.

**CONCERNS/QUERIES:**

If you have any concerns at any stage during your attachment please feel free to discuss them with a senior member of the medical or nursing staff. Your ED mentor (see below) would also be an appropriate to discuss any concerns with.

**JOB DESCRIPTION:**

A copy of the formal job description is available from Human Resources.

**FINAL COMMENT:**

Please enjoy your time in the Emergency Department, concentrate on our core tasks which are to ensure patient safety, comfort, and appropriate disposition. We are sure you will benefit from the opportunity to function with a greater degree of autonomy and the exposure to a wider case mix than you have probably had in the past.

*Nelson ED FACEM’s and SMO’s*