Emergency Department

Antrim Hospital

Doctor's Handbook

August 2017

PREFACE

Message from the Emergency Department Consultants about this book…..

As we bear overall responsibility for the treatment that patients receive throughout their time in the Emergency Department, we want to make sure that you know how to provide the best care possible. We revise this handbook once a year and distribute copies to all emergency department medical staff in Antrim Hospital.* We expect all clinical staff to read, learn and follow the guidance in this book at all times. We will circulate written policy updates throughout the year and these should be noted in the blank table supplied at the end of the book for this purpose.
This will be a very valuable resource for you irrespective of your previous experience because it is tailored to this department. Advice is also available at all times by speaking to the Emergency Department Consultant.

The handbook is divided into the following sections:

General Information Section – Blue Pages
Adult Clinical Section – White Pages
Paediatric Section - Yellow Pages
Major Incident Section – Green Pages

Emergency Treatment – Pink Pages

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*Doctors working in other Emergency Departments may find our Handbook useful, particularly if working within the Northern Area Trust. However the Emergency Department Consultants assume no responsibility for the contents of this book apart from its application in the Antrim Hospital setting. Many protocols in this book definitely do not apply elsewhere.

SECTION ONE – GENERAL INFORMATION

The General Information Section describes how the Emergency Department service at Antrim works and how doctors are expected to work within the Emergency Department team.

GETTING HELP

6666: CARDIAC ARREST:

- **ADULT or**
- **PAEDIATRIC**
- **OBSTETRIC**

6000: FAST BLEEP

- **Stroke lysis**
- **Trauma team call (indicate if paediatric team or obstetric team also needed)**
- **Anaesthetist / airway team**
- **Obs and gynae (collapsed pregnant lady or an imminent delivery)**
- **Paediatric team (if critical illness in child)**

On call bleeps: - contact the appropriate F2/CT/ST using on call bleep (daily updated sheet at all staff bases) for all critical patients. This is also the number to bleep for admissions so clearly state if you need

Contacting the Emergency Department Consultants

There is a consultant Emergency Physician in Charge ("EPIC"). The EPIC carries dect phone **331286** and is available on the shop floor Monday to Friday 8am to 10pm, Sat and Sunday 9am to 1pm. If doctors require advise they are asked to discuss with middle grade Emergency Department doctor first. If this is not possible then you can discuss with the EPIC. Out of hours the middle grade doctor can contact the Consultant on call via Antrim Switchboard (although contact numbers are also available in the Emergency Department.) If after trying the phone, mobile and bleep no answer has been received you must contact a different ED consultant. You MUST NEVER leave messages on an answer machine when trying to contact the consultant. These are the situations in which the Emergency Department Consultant on call *must* be contacted urgently

- Major Incidents (including alerts)
- Multiple Casualty incidents
- Problems with the resuscitation of any seriously ill patient
- Serious violent incidents
- Problems with Child Protection issues
- *And any other situation that seriously compromises patient care!*

ABOUT THE EMERGENCY DEPARTMENT

- *"Senior help and advice is always available*."

The Emergency Department at Antrim Hospital treats just over 75,000 new patients each year, i.e. it is a medium-sized department in UK terms. The hospital provides a wide range of inpatient services including medicine, cardiology, surgery, paediatrics, obstetrics & gynaecology, ENT and intensive care. As well as this there are outpatient-only services that include fractures, orthopaedics, ophthalmology, maxillofacial surgery and plastics. There are resident F1, and resident F2s in medicine, surgery, obstetrics, paediatrics and anaesthetics. A liaison psychiatry service is provided by the neighbouring Holywell hospital.

The Emergency Department forms a vital link between the community and the hospital –in fact it could be described as the hospital's "shop window". The main purpose of the Emergency Department service is to treat major and minor trauma and various medical and surgical emergencies. As well as fulfilling this main role, we can help people to gain access to a wide range of services in primary care (general practice), community care and hospital outpatient departments. Our catchment area extends from the northern outskirts of Belfast, to towns like Antrim, Magherafelt, Ballymena and Larne. We also serve a large rural population and the villages along the Antrim Coast. The result is endless variety! We have to cope with classical 'inner city' patients including the socially deprived. This will include drunk and aggressive patients at times as well as a large number of patients who probably should have gone to their general practitioner but found the hospital more convenient! We also see the classical rural patient who only seeks medical attention as a last resort; often with florid pathology.

This is a very challenging environment in which to practice medicine but it is an excellent place to learn. There is a good mixture of minor and major cases in medicine, paediatrics, surgery, general practice, psychiatry etc. and an opportunity to follow up the patients who you have seen.

The Emergency Department medical team has eight consultants, one associate specialist, three staff grades, six ST4+ and thirteen doctors in Foundation / Core training…. *SENIOR HELP AND ADVICE IS ALWAYS AVAILABLE*.

The department has senior nursing sisters (main department &observation ward), over 65 nurses and a plaster technician. The senior nursing staff have extensive experience as well as a knowledge of how things are usually done in the hospital. This will be particularly helpful for doctors who are new to the department. There is always a 'Triage Nurse' on duty. He/she sees all patients

within fifteen minutes of arrival and prioritises them according to medical need. (the Triage Scale is described later in this book). Many of the nurses have extended skills such as cannulation, venepuncture and suturing. There are Nurse Practitioners who independently treat patients with a range of minor conditions. A nurse practitioner is on duty from 9am - 9pm every day.

THE EMERGENCY DEPARTMENT DOCTOR'S ROTA

- *"Leave is on a first-come-first-served basis"*
- *"Changes must be marked clearly on the notice board copy of the rota"*

Breaks are rostered into your shift, ensure that you take them.

1) Doctors in training

Emergency Department F2s and STs work a full shift system involving a basic 50 hour week on average. Regular Emergency Department shifts last for nine or ten hours – ie. eight to nine hours of work with 30 mins break every four hours or so. Emergency work permitting, STs will take a 30 minute break in the Emergency Department after every four hours of duty. At the end of their shift, doctors are expected to stay on duty until they have sorted out or handed over all their patients as well as helping during extra busy spells.

Annual Leave: Annual leave and days in lieu of stat days worked is built into the rota. If swaps are required please arrange this amongst yourselves.

Study Leave: study leave will be granted as per contract and service demands. Six weeks notice must be given for all F2/GP study days. All other study leave/exam requires six weeks notice and will be granted at the discretion of your ED Educational or Clinical Supervisor.

2) Middle Grade Doctors

The middle grade rota is produced by Dr Jenkins' secretary according to a rotating template. Copies are available from her. Only one of the middle grade doctors can be on leave at once. In general, leave must start on a Monday and finish on a Sunday – any deviation from this requires specific consultant permission. Leave is booked with Dr Jenkins.

TRAINING IN THE EMERGENCY DEPARTMENT

1. Before you start

It is expected that you will have completed the mandatory Trust and Right Patient, Right Blood haemovigilance training.

www.spottingthesickchild.com is a valuable e-learning resource to help healthcare professionals to recognise children with serious illness. Any trainee that cannot demonstrate competencies in managing children with serious illness ie. do not hold a valid APLS/EPLS certificate, must compete this e-learning within two weeks of starting your ED placement.

2. Induction

Induction is mandatory. The aim of induction is to introduce to the style of working expected in the ED (which is very different from any other department within the hospital) and to ensure safe and efficient care of patients. Homework cases will be issued and should be completed prior to the relevant teaching session.

3. Teaching

F2s' and ST1-2s' contracted weekly duties include a compulsory protected teaching & audit session from 9am every Thursday 8am on Friday. Full attendance as per rota is mandatory (non-attendance will result in allocation of compensatory extra duties and will also result in unsatisfactory appraisal reports and references). You MUST sign the attendance sheet every time as this is the basis for your certificate of training attendance when you leave.

ST4+ training is co-ordinated through NIMDTA and full attendance is expected. It is expected that you will also participate in the weekly journal club and bimonthly morbidity and mortality meetings. ST4+ doctors should use this opportunity to develop their own teaching skills by being involved in junior doctor teaching.

3. Supervision Meetings / E-portfolio

Doctors in training are expected to arrange their initial interview with their ED Educational or Clinical Supervisor within two weeks of starting their ED placement. This can be arranged through the Consultant's secretary. Review interviews at mid point and end of placement are arranged in the same way.

It is your responsibility to keep a contemporaneous e-portfolio and log book in accordance with your College's recommendations. Many opportunities will present for completion of Work Based Assessments in the ED.

4. Audit

All doctors in training will be expected to participate in and present at least one full audit cycle during their ED placement. We participate in the CEM audits (which change annually) and you may be allocated to one of these teams though you are free to choose your own audit topic.

UNPLANNED LEAVE

1. Sick Leave

If you are sick you must inform the EPIC by phone (ext 1286) and email Adrian McLaughlin in medical personel to inform them at least one day before the start of your shift or in exceptional circumstances, within one hour of the time you were due to go on duty. *Failure to do this would constitute a serious breach of your professional responsibility.*

You must provide the following information:

- Your shift
- the reason for your absence;
- how long you are likely to be off;
- what action has been taken by you in respect of your illness e.g. doctor's appointment

In some circumstances you may not wish to discuss your reason for absence with your manager. If this is the case, you will be referred immediately to Occupational Health, to facilitate the management of your absence.

A return to work interview should be completed by your Education / Clinical Supervisor or the EPIC on the day your return. This information will be held by the directorate office.

Employees who become unfit for work during a period of annual leave must notify their manager on the first day of sickness absence, or as soon as possible, in accordance with this protocol and not wait until they return to work. Certificates should be provided as above. If these conditions are complied with, the annual leave will be converted into sick leave and the annual leave credited back to the employee. Otherwise this will result in the loss of annual leave. Employees will not be entitled to an additional day off if sick on a Public Holiday.

Prospective cover (up to 72 hours): In line with NHS terms and conditions, the other doctors covering your part of the rota will be required to cover all sick leave unless long term sickness is involved. In practice, this will involve longer shifts for those already on duty and extra nights for those on night duty if you were due to do the nights. Standard renumeration is added for these extra shifts but they cannot be paid back – it is our duty to support the sick colleagues on our rota in the short term.

Sick Leave in Previous Employment

It is your professional duty to disclose any periods of sick leave in the proceeding twelve months prior to this placement. This should be disclosed at your initial supervision interview.

A word about infectious diseases…

We have high medical sickness rates due to gastroenteritis, presumably contracted from patients most of the time. Reduce your risk of this by adhering to hospital infection control procedures – hand washing works! Wear scrubs or hospital-only clothes to reduce the risk to your family. Don't eat or drink in clinical areas even on night duty. Try to stay fit during your time in EM to keep your immune system working well despite the disruption of shift work.

Referral to Occupational Health

Sick leave rates, especially casual leave, are closely monitored and almost always are disclosed on references. Doctors will be referred to Occupational Health if three or more periods of sick leave within twelve months employment as per the Northern Trust Managing Attendance Policy and Procedure Policy 2011. Immediate referral to occupational health may be considered in other circumstances such as injury at work, stress, period of illness anticipated to last greater than four weeks.

2. Carer's Leave / Compassionate Leave

Special leave such as carer's leave or compassionate leave my hbe available to you if you have an issue with your private life, child care concerns or bereavement. This is usually at the discretion of your Educational / Clinical Supervisor.

3. Maternity / Paternity Leave

This is as per the terms and conditions of your contract.

WORKING IN THE EMERGENCY DEPARTMENT

- *"It is essential that you always look like a doctor"*
- *"Treat patients and their relatives in the way that you would like to be treated in the same situation"*
- *"If you are having difficulty with the treatment of a seriously ill patient get help immediately*."

In order to become a good ED doctor you need to develop the ability to deal with patients very rapidly and to never appear to rush them, while making sure that you make the right decisions about their management. This is, of course, virtually impossible! If you don't learn to work quickly when there are a large number of patients in the department, you may rapidly become overwhelmed by the queues waiting for your attention. At the same time, it is important that you are tolerant with your patients and that you always appear to have time for them - even when you don't.

Emergency medicine is very challenging. Many of your patients will be so ill that you will have to start resuscitative treatment before you have any idea what is wrong with them. Others will have symptoms which sound very serious but which are due to relatively harmless conditions. One of the best ways of saving time is to work on your clinical skills so that you can make reasonably accurate diagnoses without ordering unnecessary blood tests and x-rays. The CLINICAL section of this book will be invaluable. There is more information about how to approach emergency medicine problems and about common diagnostic pitfalls later in this section. Practical sessions on resuscitation during the Induction Course should give you the confidence required to commence resuscitation in every situation. *If you are having difficulty with the treatment of a seriously ill patient* <u>*get help immediately.*</u>

- *It is essential that you always look like a doctor* - this means dressing professionally -hospital "scrubs" are preferred. Introduce yourself to every patient and their relatives as well as wearing your identity badge. If you involve junior or senior colleagues in a patient's care, introduce them as well.

- *Treat patients and their relatives in the way that you would like to be treated in the same situation*- patients appreciate this more than anything else. Remember that you are going to make mistakes - your patients will usually forgive a great deal provided you have treated them considerately.

- Be careful about people who are 'just visiting' the Emergency Department. Please do not bring unauthorised visitors into an area where patients are being treated. The medical students in the department are your responsibility and remember that any patient is entitled to refuse to be seen by students.

- Students must never *treat* children (e.g. by suturing, taking blood etc)

- Doctors who are not part of the Emergency department's staff cannot come and work here without the Emergency Department consultants' permission.

- NO doctor in the hospital should use the Emergency Department to self-treat or self-medicate except for minor aliments

- Social Media is an increasing part of our lives. However doctors are expected to conduct themselves professionally, no patient identifiers should be used or photos taken whilst at work. Be aware that what you post online will reflect not only on you but also the department as a whole.

1. Communication and patient tracking

In the Emergency Department, relatively large numbers of patients flow through a sequence of assessment and treatment areas that are physically separated from each other. Staff in each area will be constantly receiving and handing over patients so effective communication between areas is essential. The *electronic tracking system* 'Symphony' is central to the administration of patient flow through the Emergency Department. The 'Symphony' system enables an appropriate member of reception, nursing or medical staff to mark each stage of the patient's journey on an electronic tracking system as each element of registration, assessment or treatment is completed. The tracking data must be entered accurately and in real-time by staff 24 hours each day – it is confidential and should not be viewed by unauthorised personnel. There is also a patient tracker from 10am to 10pm every day to assist with this.

Please remain professional during all communications with other healthcare professionals. Handover of patients should be made using the SBAR tool as detailed below. The handover should be recorded on the ED flimsy and on Symphony including name, grade and contact details.

Safer Patient Initiative

S	ituation What is going on now?	▪ State your name and Ward / Department ▪ I am calling about patient's name ▪ The reason I am calling is ..... ▪ Observations are
B	ackground What has happened?	▪ State the admission diagnosis and date of admission ▪ Relevant medical history ▪ A brief summary of treatment
A	ssessment What you found / think is going on	▪ State your assessment of the patient ▪ Have appropriate documents available, e.g. EWS, nursing and medical records, resus status, allergies etc
R	ecommendation What you want to happen	▪ I would like (state what you would like to see done) ▪ Determine timescale, e.g. NOW! ▪ Is there anything I should do? ▪ Other referrals? e.g. Acute Care Team

Do not forget to document the call

The Maintenance of computerised records is a clinical governance issue - persistent failure by an individual to fill out and update patients data, will be dealt with via the Trust's formal disciplinary procedure.

GP letters are generated from the information in the DADT box on Symphony, they are the main form of communication from the ED to the GP. Ensure clear diagnosis, pertinent clinical findings and patient instructions are detailed. Also detail any follow-up arrangements, especially if GP involvement is required. When early GP review is required please print the summary letter and ask patient to deliver it to the GP. Never phone the GP to complain, raise any issues with a senior ED doctor first.

2. Patient records (see Symphony section)

Permanent patient records will be held electronically on the department's 'Symphony' system. After registration admin or clinical staff will print out a multidisciplinary paper flimsy at a print station. Patient labels can be generated at the same time. Once patients are discharged from the ED and after completed flimsies are scanned onto symphony, the paper version can be sent to a ward or fracture clinic etc (see Symphony Policy) The data eg your name, diagnosis and "DADT" generate an automatic GP letter so you MUST complete these EVERY time AS YOU GO ALONG – not optional and no-one else can do it for you.
The Freedom of Information Act 2000 gives patients the right to read their notes and frequently request copies from Medical Records.

3. Patient friends and relatives

Relatives and friends should remain in the room with the patients, if a patient is not in a room they are limited to one relative due at the bed side. Relatives should be invited to wait in the waiting room when personal/intimate assessments and treatments are being conducted. Always gain verbal consent from the patient for relatives to remain during other assessments unless unable to consent eg. A vulnerable patient. Relatives of gravely ill or distressed patients should be escorted to the Relatives Room by a senior nurse or doctor.

4. Night Time

3 Doctors will work overnight one senior and 2 junior, any queries on patient care should be initially directed to the senior doctor who will advise on their management, if necessary they may need to contact the Consultant on call.
When the department is busy “barn door” admissions should be speedily referred on to the speciality teams with the minimum of ED input provided they are STABLE. Rules for access for relatives and members of the public apply all night. Doctors on night shift should not leave the department.

5. Access/Egress

Access, egress and patient flow will be strictly controlled by door-locks and code access. Unauthorised personnel (public or staff) are not permitted in the department. All essential staff who are required to visit the ED will be circulated with information about how to access the department. The ED will not be used as a through way at any time.

6. Junior Doctor Working Model

Junior and senior doctors work together in Antrim Hospital Emergency Department to provide the best care possible for our patients. There will be a daily allocation sheet of where you are supposed to work which also details the EPIC and consultant on call. In the past junior staff medical staff asked for help whenever they felt they needed it, senior input was often sought at the end of a patient journey. In this department we want to have input from the start of a patient’s journey. If you have any concerns it is your duty to report to this consultant.

Consultants will conduct ward rounds at 8am and 10pm with the whole team. This is to aid in decision making and facilitate handover. It is recognised as good practice by our College.

The ED is an excellent training area for junior doctors. Our working pattern is not supposed to stop you from thinking or working. This is an aid so you can see many patients rapidly and safely and to teach you how to make the right decisions. We want you to use the right tests for the right patients. There will be a senior doctor working beside you 24/7. We expect everyone to work together in this team-working model.