Dandenong Hospital Emergency Department

Site-specific Orientation information

This is a brief local supplement to the over-arching Monash Health Emergency Department: Medical Orientation Manual. The latter contains all the relevant generic information about the Emergency Department (ED) philosophy, your duties and work practices which are uniform across all the Monash Health EDs. You must read that document in full. This document provides some additional site-specific information.

DH ED Administration

Important staff

	Dandenong Hospital Emergency Department
Emergency Service Director	Neil Goldie
Director of Emergency Medicine	Frank Soden
Deputy Director of Emergency Medicine	Jennifer Kim-Blackmore
Director of Emergency Medicine Research	Prof. Andis Graudins
Director Education	Sheila Bryan
Directors of Emergency Medicine Training	Shemma Hasanovic & Di Flood
Quality Assurance, Risk management	Robert Meek
HMO Supervisors	Nagendran Mathavan & Eva Chong
Intern Supervisor	Ken Hii & Richard Haydon
Medical Student Supervisor	Kirsty Povey
Other Emergency Physicians:	Jim Barton, Trudi Davis, Dino Druda, Suzan Fox, Steve Guastalegname, Richard Haydon, Ciaran Joyce, Hwee Min Lee, Wendy Lim, Melanie McCann, Jason Nebbs, Michelle Philander, Ananth Sundaralingam, Susan Tucker, Igor Tulchinsky, Malinda Weerasinghe, Sam Kim Moe, Alex Duong, Caroline Bolt, May Chang, Dimi Giannios
Nurse Unit Manager	Kate Sandry, Niki Spry
Nurse Educators	Jennifer Jackman, Tanya Mosbey
Clerical Team Leader	Suzana Alimi
Care Coordination Team Leader	Phillipa Stewart
Pharmacy Team Leader	Jaime Vallejo (9554 9950)
ED secretary	Yonne Skroubelos (9554 8475)
ED administrative lead	Dale Ferguson (9554 9906 / 0488 607 365)

Department Overview

Dandenong Hospital (DH) Emergency Department consists of a combined adult and paediatric emergency department. In total DH ED has 63 treatment spaces including 18 short stay beds, 4 resuscitation bays and 2 procedure rooms. On average DH ED has 193 presentations per day, or 70336 per year. A large percentage of these are high acuity, and approx. 25% are paediatric patients.

DH provides clinical services for all medical and surgical sub- specialities, however definite management for Stroke and STEMI is via Monash Medical Centre (MMC).

Orientation

Approximately 4 weeks prior to commencing work at DH ED, you will be emailed a welcome letter and a request to arrange an Orientation date with Dale Ferguson.

Prior to commencing your first shift, you will be given an extensive orientation by Dale Ferguson. This includes a tour of the department to familiarise you with the cubicle layout and resources available.
At the start of your first shift, you should present to the consultant in charge (CIC) for that shift.

Education Opportunities

Dedicated protected teaching time is included on Thursday afternoons from 12.30pm- 1.30 pm for all DH Interns. At this time, you can leave your day shift to attend this teaching. You are also welcome to attend if you are not rostered to work that day.
There is also a DH ED teaching session for Interns on their DH ED rotation, held once a month on a Friday.

Intern Teaching (Mandatory & Protected)	Thursday	12.30pm-1.30pm	Seminar Room 1
ED Intern/Medical Students	Friday Once a month	1.00pm- 4.00pm	Wenzel room

Assessments

The Interns Supervisors (DR Ken Hii and Dr Richard Haydon) will conduct a written Mid-Term and End of term Assessment for each Intern. The HMO supervisors (Dr Eva Chong and Dr Nagendran Mathavan) will conduct written End of term Assessment for each HMO.

Contact for leave

Annual Leave: Dale Ferguson (for HMO and intern)

Sick Leave: All notifications (any time) go to Dale Ferguson. His phone is on from 7am to 10pm. After hours sick call can wait until 7am.

Late for shift: Notify Consultant in Charge on 9554 9900 (AM) or 9554 9901 (PM).

Learning Objectives

At the end of this rotation, the prevocational doctor, under supervision, will be able to:

1. **Science and Scholarship**
   - Consolidate expand and apply knowledge of aetiology, pathology, clinical features, natural history and prognosis of common emergency presentations
   - Access and use relevant treatment guidelines and protocol (prompt)
   - Seek and apply evidence to emergency patient care
2. **Clinical Practise**
   - Assess patient with acute, undifferentiated illness
   - Demonstrate appropriate history taking and physical examination
   - Develop management plans
   - Order and interpret investigations
   - Participate in decision making
   - Observe, learn and perform a range of procedural skills (e.g. IDC insertion, Cannulation, Plastering, Suturing, venepuncture, Lumbar puncture). Interns and HMOs may also be given opportunity to perform other resuscitation procedures, where possible, such as cardioversion, DCR under the supervision of Senior Medical Staff
   - Prescribing of medications, fluids, blood and blood products
   - Develop skills in synthesizing acute management issues and presenting a concise patient assessment
   - Develop skills in preparing appropriate medical documentation including
     a) Records of clinical interactions
     b) Discharge letters and summaries
   - Develop effective communication skills
   - Develop skills in obtaining informed consent, discussing poor outcomes and end of life care in conjunction with experienced clinician.
   - Below are some common ED presentations and prompt guidelines:
     a) **The deteriorating patient.** This may occur while the diagnosis is still unclear, know how and when to escalate, and be familiar with basic life support
     b) **Headache.** Migraine is common, but important not to miss haemorrhage and meningitis
     c) **Limb or face weakness.** Stroke and TIAs are common. Be familiar with calling the stroke team. (PROMPT : Code Stroke; Transient Ischaemic Attack/Stroke)
     d) **Altered conscious state**. Many possible contributing factors, don't miss sepsis, seizures, toxicology or glucose abnormalities. (PROMPT: Diabetic Ketoacidosis diagnosis and management (Adult))
     e) **Shortness of breath**. CCF, obstructive lung disease and pneumonia are all common. Don't miss PEs or a pneumothorax.
     f) **Chest pain**. Ischaemic disease is important to rule out, but also consider pleuritic pain (e.g. PE, Aortic dissection). (PROMPT: Chest pain Assessment Emergency Department; Monash Heart ST Elevation Infraction (STEMI))
     g) **Abdominal pain**. A common ED presentation, consider the Surgical (e.g. acute abdomen, appendicitis, mesenteric ischaemia) and non-surgical causes (e.g. pancreatitis, pyelonephritis, renal calculi). Diagnoses not to miss include AAA. Beware the elderly with

abdominal pain. (PROMPT: Abdominal Pain Adult Emergency Department; Renal Colic (Adult) Emergency Department; Acute Scrotal Pain)

h) **Mental Health**. Many conditions can contribute behavioural disturbances. Psychiatric diagnoses such as depression, schizophrenia, and psychosis are common. However, do not forget to consider acute organic cause.

i) **Trauma.** Fractures and other trauma presentations are common. (PROMPT: Blunt chest trauma in the elderly Assessment and Disposition; Assessment and Management of Post Traumatic Amnesia in Acute Traumatic Brain Injury (Adults); Trauma Response (Adult) Emergency Department)

j) **Paediatrics.** In most EDs you will see paediatrics. Consider whether you have an approach to the paediatric patient, and the most common conditions seen (e.g. asthma, bronchiolitis, gastro)

k) **Vaginal bleeding.** This is quite common, review your approach to this presentation in different age groups.

l) **Back Pain.** Commonly due to musculoskeletal cause. Be aware of possible spinal injury and red flags for cauda equine.

3. Health and Society

a) Discuss allocating resources in providing emergency care
b) Participating quality assurance/risk management
c) Screen patients for common diseases, provide care for chronic diseases and discuss healthcare behaviour with patients
d) Develop knowledge about how patient care interacts with subacute, community and ambulatory care facilities, including appropriate discharge destinations and follow up

A) Professionalism

a) Develop skills in prioritising workload
b) Demonstrate an understanding of roles, responsibilities and interactions with various health professionals
c) Participating actively in multi-professional/disciplinary team
d) Develop and reflect skills and behaviours for safe professional and ethical practise consistent with the Medical Board of Australia Good Medicine Practise: A Code of Conduct for Doctors in Australia

Roster

You will be rostered as per contract, 76 hours per fortnight.
This comprises a mix of Day, Evening and Night shifts. ED comprise 3 working streams: Main Stream, Fast Track, and Short stay unit (SSU) and you will be allocated to these streams. Interns do not do SSU night shifts, this role is filled by HMOs.

Dale Ferguson does the roster for all Interns and HMOs.
You can access you roster via findmyshift online and will be given a password prior to starting work. Shift swaps: Doctors must be same level of seniority. All requests go to Dale Ferguson.

Upfront Decision Making Model of Care/Clinical Areas

Main Stream is divided into RAP (Rapid assessment and Planning) Zone (A4-A11) and Acute Cubicle Zone (A12 – A26)

- RAP area (A4-A11), it can be used by both orange and silver team, this will be assigned by RAP nursing team leader
- Cubicle A8 (orange) and A9 (silver) is called swing cubicle. It is for doctors and nurses to assess patient and do appropriate initial investigation and/or start initial treatment. The patient assessed in swing cubicle then should go back to either RAP chair or waiting room.
- RAP chair is a waiting area inside the department for patients awaiting assessment. RAP nursing team leader will also assign patients to this area.
- The patients in RAP area should be discussed with the consultant in charge or senior registrar in charge overnight as soon as assessed by a doctor.
- Consultant in charge will decide on investigation/treatment plan/disposition. Patient will then be moved to acute cubicle zone, SSU or to the waiting room/RAP chair.

Fast Stream: cubicles F1 – F7, F 15-16, Procedural Room 1-2

- All FT 1-6 should be used as Swing cubicles. FT 1-4 has either a bed or a reclining chair to assess patients. FT 5 has eye and ENT equipment. FT 6 has door that can be closed for more privacy such as gynaecological complaints.
- FT 15 and 16 and FT 7 are nursed and usually for those needing more nursing care.

Short Stay Unit: beds S1 – 14, S17-20

Other cubicles:

A1-3 (Resuscitation bays) + Iso 1 and 2 may be used for both Orange and Silver Team

Bar room 1 is used for patients with behavioural disturbance (e.g. section 351)

Contacting Specialty Registrar

In Hours/Evening – Page or phone via Switch 91

From 2200

- Page via SmartPage for non-urgent tasks
- On Dandenong intranet page under contact
- Location: Dandenong → Emergency, Password: Emergency
- Medical speciality referrals from ED that does not require urgent or immediate speciality registrar input (from 2200-0600) gets referred to Night Medical Lead (GM advanced trainee who is based at Clayton) For specific See Night Medical Lead on PROMPT guideline

Specifics of shift commencement and handover

General clinical duties and mode of practice is detailed in the full Monash Emergency: Medical Staff Orientation document. These need to be known and followed.

The following are Dandenong site-specific shift commencement and handover routines

Shift commencement

Day shift: At 0800, all night shift doctors, the day shift RAP and Fast Stream doctors, and the day shift SSU doctors, are to 'huddle' in the Main in-charge area. The day shift Consultant-in-Charge will lead a discussion regarding any specific shift issues or goals. All staff must congregate promptly so that the Main Stream clinical handover can follow in a timely fashion.

Similar medical shift commencement 'huddles' are not presently held at the commencement of evening and overnight shifts.

Handover routines

Overnight to day shift:

Main Stream: (shift commences 0800)

- commences after conclusion of the 'huddle'
- Team based, overnight Orange to day shift Orange and overnight Silver to day shift Silver , regardless of patient location within the ED (other than SSU)
- In general, the junior doctor on the Team will commence seeing new patients and not take handovers, and the Team Leader will take the handovers of all the admitted/stable patients waiting for beds. The Team Leader will decide who takes the handovers of patients still being worked up.

Fast Stream: (shift commences 0800)

- No specific handover as patients are not triaged to Fast Stream overnight
- On occasion, the Main Stream CIC may allocate handovers to Fast Stream of patients in the Waiting Room who are still being worked up, and who meet Fast Stream triage criteria.

Short Stay Unit: (shift commences 0730)

- Occurs between all overnight Main Stream doctors with patients in SSU, the SSU overnight HMO, the day shift SSU team (Emergency physician + Intern), ED pharmacist, ED Care coordinator and ECAT team.
- The day shift SSU team take the handovers of all patients in SSU at that time, and of patients from Main Stream who are expected to be moved to SSU before 8.30am.

- The day shift SSU team do not take handovers of patients who are moved to SSU later in the shift. These patients remain under the care of the initially treating doctor (all Streams).

Handover routines

Day shift to evening shift

SSU: (evening shift interns usually commence at 1430 in Main, seeing patients as directed by Orange CIC, until handover time at 1630 to 1700)

- Commences at 1630 in the Corridor between Main and resuscitation area.
- Handover is taken by the evening SSU intern. Both Orange and Silver consultant should be present as they will be supervising the patients in their own stream. Fast track patients in SSU will be supervised by Fast Track consultant.
- The evening shift SSU intern can also take patients who are in the main department who are waiting for an SSU bed. This is at the discretion of Consultant in charge.

Main Stream: (evening shift staff commence between 1400 and 1500)

- Commences after SSU handover in the main Doctor's area.
- Team based, day shift Orange to evening shift Orange, day shift Silver to evening shift Silver.
- In general, the junior evening shift doctors will not be involved and the Team Leader will take the handovers of admitted/stable patients waiting for beds. The Team Leader allocates the handovers of Main Stream patients still being worked up.

Fast Stream: (evening shift staff commence between 1400 and 1500)

- Patients from the day team will be handed over to evening FT consultant. It will be at the discretion of the FT consultant to handover to another staff, but he/she needs to know about all handed over patients.
- All patients from the day shift now in SSU are handed over to the SSU intern, under the supervision of Fast track consultant

Handover routines

Evening shift to overnight shift

SSU: (overnight SSU HMO commences 2300)

- Commences at 2300 in the Corridor between Main and resuscitation area.
- Handover is taken by the night SSU HMO. Senior Clinician supervising SSU overnight should be present.
- The night shift SSU HMO can also take patients who is in the main department who is waiting for SSU bed. This is at the discretion of Senior Clinician in charge.

Main Stream: (overnight shift staff commence 2300)

- Commences after SSU handover in the main Doctor's area.
- Depending on the senior clinician overnight, will either be team based or one handover to the overnight senior clinician.
- In general, the junior night shift doctors will not be involved and the Team Leader will take the handovers of admitted/stable patients waiting for beds. The Team Leader allocates the handovers of Main Stream patients still being worked up.

Fast Stream: (not separately staffed overnight)

- No new patients are triaged to Fast Stream after 2300, with the expectation that as many already waiting will be attended by 2400. Residual patients triaged to Fast Stream but not seen by 2400 will have their Care Groups (on Symphony) reallocated alternately to Orange and Silver by the Nurse-in-Charge.
- All Fast Stream patients in SSU are handed over to the overnight SSU HMO under the direction of the Senior Clinician in charge overnight at 2300.
- All Fast Stream patients still being worked up in Fast Stream are allocated to Orange Team doctor as allocated by the Orange Team Leader. (These should be very few in number.)
- The Care Group must be changed from Fast to Orange at this time.

Specific routine duties of the SSU interns

Besides providing direct patient care as required, and ensuring that management plans are progressed towards completion, there are some additional specific requirements. General philosophy and work practice are detailed in the over-arching Monash Emergency: Medical Staff Orientation.

The following are some site-specific additional requirements.

Day shift SSU Intern

- Below checklist should be done on every single patient you have taken over. Laminated copy will be available for reference.

	Checked
Vital signs including conscious state	
Blood/Radiology/ECG result	
Pain control	
Medication chart - **Correct label** - **Allergies documented** - **All necessary drug charted with correct dose and time** - **Insulin (if applicable)** - **VTE (if applicable)** - **Fluid (if applicable)**	
Patient understanding	

- The above may be done during a formal consultant ward round, if one is being conducted
- At least one update progress note must be added to Symphony for every patient on every shift
- When there are no specific duties remaining for SSU patients, the intern moves to Fast Stream to see new patients under the direction of the Fast Stream senior doctor
- Be ready for handover to the evening shift SSU interns in Main Stream by 1630

Evening shift SSU Intern

– Below checklist should be done on every single patient you have taken over. Laminated copy will be available for reference.

	Checked
Vital signs including conscious state	
Blood/Radiology/ECG result	
Pain control	
Medication chart - **Correct label** - **Allergies documented** - **All necessary drug charted with correct dose and time** - **Insulin (if applicable)** - **VTE (if applicable)** - **Fluid (if applicable)**	
Patient understanding	

- At least one update progress note must be added to Symphony for every patient on every shift
- When there are no specific duties remaining for SSU patients, you return to Main Stream to see new patients in either Orange or Sliver team. The Team Leader will endeavour to allocate less complex patients, in order that the intern can return to SSU as required.
- Be ready for the Main Stream area handover at 2300.

Overnight SSU HMO

- Below checklist should be done on every single patient you have taken over. Laminated copy will be available for reference.
- Patient understanding will be dependent on whether patient is awake overnight.

	Checked
Vital signs including conscious state	
Blood/Radiology/ECG result	
Pain control	
Medication chart - **Correct label** - **Allergies documented** - **All necessary drug charted with correct dose and time** - **Insulin (if applicable)** - **VTE (if applicable)** - **Fluid (if applicable)**	
Patient understanding	

- At least one update progress note must be added to Symphony for every patient on every shift
- When there are no specific duties remaining for SSU patients, you return to Main Stream to see new patients under the direction of the Orange Team Leader. The Team Leader will endeavour to allocate less complex patients (e.g. those who would be triaged to Fast Stream at other times), in order that you can return to SSU promptly when required.
- At 0600, you must be back in SSU and check without interruption:
    - Vital signs of all patients in SSU (regardless of treating doctor), report any meeting MET criteria to the consultant immediately
    - Medication Charts of all patients in SSU (regardless of treating doctor), for completeness/accuracy. This is to ensure that all patients receive their correct morning medications.
    - This is considered the most important safety check of the day for SSU patients.
- Remember, you are still generally responsible for progressing the management plans of the patients you took over, which may include early morning discharge (e.g. after check of repeat results, having family pick up etc.). Whenever possible, patients ready to go should be discharged by 0730.
- Be ready for handover at 0730.

Conclusion

- Any administrative enquiries can usually be managed by Dale Ferguson
- Lines of consultation are team-based, as outlined above
- General issues or difficulties of any type may be referred to the supervisor for your level