NGH ED

NHS
Northampton General Hospital
NHS Trust

Junior Doctor Handbook

August 2020

Foreword from the Head of Service

Welcome to the Emergency Department at Northampton General Hospital – or NGH ED for short.

I sincerely hope that you will enjoy your time with us, and that over the course of the next 4/6/12 months (or longer) you will get to know us, and we you. Northampton Emergency Department, and the hospital as a whole, prides itself on being a friendly place to work and we hope that - with time, you will feel part of the family that is NGH ED.

Over the next few months you will meet people on what is, for them, the worst day of their life. As a doctor working in Emergency Medicine, you will have the privilege of being one of the first people they meet on their journey through NGH. Take the time to get to know patients as individuals, since it is through this that you will understand what is concerning them and be able to instigate appropriate treatment. At the same time, don't be afraid to ask for help when you are uncertain. Help will always be available if you ask for it.

It would be naïve of me to think that you aren't aware of current affairs and some of the challenges that we face in Emergency Medicine around patient flow, exit block and of course, COVID-19. However, you will find during the most challenging of times that everyone comes together, and the department really does work as one team. It is this camaraderie that I feel defines us as a department and a speciality. Every year we have comments from trainees on rotation that this is the most welcoming department they have worked in, and we hope that you will share this sentiment.

Should you have any gripes, concerns, or worries please don't hesitate to come and speak to me or one of my colleagues, our door is (metaphorically) always open.

Finally, on behalf of the senior nurses, managers and consultants, I would like to welcome you to the Emergency Department family.

I look forward to meeting you,

Best wishes,

John

Dr John Trenfield
ED Consultant and Head of Service

Contents

The Royal College of Emergency Medicine

On the 29th February 2008, The College of Emergency Medicine became a College by Royal Charter. It was established to advance education and research in Emergency Medicine. On the 4th February 2015, The College was granted the title Royal by Her Majesty The Queen, becoming the Royal College of Emergency Medicine.

The College is responsible for setting standards of training and administering examinations in Emergency Medicine for the award of Fellowship (FRCEM) of the College, as well as recommending trainees for a Certificate of Completion of Training (CCT) in Emergency Medicine.

The College works to ensure high quality care by setting and monitoring standards of care, and providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine.

Taken from www.rcem.ac.uk

About NGH ED

We currently see approximately 350-400 patients/day (increasing by ~5-10% per year) and serve the southern part of Northamptonshire, the county town and surrounding areas. We are a Trauma unit within the Central England Trauma Network and have the hyperacute Stroke Service. Although we have a Cath lab in the Heart centre (above ED), the 24/7 Primary PCI suite is based at Kettering General Hospital – however patients presenting during working hours may well be seen and treated at Northampton.

The department is split into the following areas:

- **Streaming**. Streaming practitioners (nurses or paramedics by background) assess patients when they arrive and direct them to the most appropriate facility (either within the department or externally).
- **FIT**. This is where patients are assessed and have initial investigations and treatment commenced via our IATs (Initial Assessment Tools) – available on the intranet and via ICE. Typically, registrars will be asked to assist in this area in ordering appropriate imaging and identifying patients who should be referred direct to the inpatient teams.
- **Majors**. Most patients will be streamed to this area of the department after they have been assessed in FIT. Patients who need a trolley will be in a room, however those who are "#FitToSit" and do not need a trolley will be in one of the waiting areas. If you are seeing a patient in the waiting area, we have 'in and out' rooms (check with the nurse-in-charge which room(s) are allocated that shift). You can take a patient into one of these rooms to assess them, but please return them to the waiting area afterwards so that others can use the rooms. If you see a patient who you feel needs to be on a trolley, discuss with the nurse in charge who will allocate a room.
- **Majors lite** is the term used to describe ambulatory patients who have self-presented to the department. Where possible a doctor will be allocated to work in this area.
- **Paediatrics**. Adjacent to majors this area contains a play area and four rooms to see patients. It is staffed by at least one paediatric trained nurse 24/7. *There are plans to expand paediatrics significantly, this may change whilst you are with us, more to follow…*
- **GEM** stands for Geriatric Emergency Medicine. This is the area at the far end of majors and comprises 4 rooms with 1 nurse and 1 HCA. Where possible elderly or confused patients will be allocated to these rooms.
- **Resuscitation room**. This has 9 spaces; rooms 1 & 9 are our adult and paediatric trauma / cardiac arrest bays respectively and contain everything required for patient management. There are a further 3 side rooms (2-4) & 4 curtained bays (5-8). The ambulance pre-alert phone is in resus and staff tannoy that there is a 'red call' en route with an ETA. Adjacent to resus is our End of Life room and the Hannah Payne relatives' room.
- **Minors**. This area is managed by our ENPs and covers adults and paediatrics. A plaster room is located opposite room 21 in majors.
- **Clinical Observation Area (COA)** is a short stay facility for patients who we think will go home but need to wait for a blood test, imaging report, mental health assessment, or similar. Admission is protocol driven, the patients NEWS must be <2, and the form signed by the doctor & nurse in charge of the shift before the patient is transferred. Be aware that this is a low dependency area and consequently admission is much stricter than

other hospitals that you may have worked in. Additionally, no medical staff are assigned to the area, so you remain responsible for patients you transfer to this area.

- **Springfield** is located outside ED, turn left and it's the Victorian building to the left. This is where our GP service is based. Some of the senior team also have their offices upstairs.

Nearby departments

The following are areas of the hospital that you may need to visit during your time with us:

- **Imaging** (X-Ray, Ultrasound & CT) follow the green line on the floor by the nurses' station, past COA and straight on. X-Ray & CT3 are on the right with Ultrasound, CT1 & 2, and the Advice Radiologist (for discussions about imaging) straight ahead – however you should generally contact x4266 to discuss imaging requests with the radiologist.
- **Café Royale** (Café Posh as it is also known) is next to main reception and can be accessed either by turning left just before X-Ray, or by leaving via the main ED entrance then turning right and walking in via main reception. They do good coffee!
- **Ambulatory Care Centre** (ACC) is opposite Café Royale.
- **Canteen**, down the stairs adjacent to resus, turn left and keep walking. About halfway down hospital street on the right opposite the Chapel.
- **Bereavement Centre**, as for the canteen but keep going, turn right at the end of the corridor and go up the hill. Follow signs for the board room and it's on the left. This is not a short walk - probably about ten minutes…
- **Library**, head past the canteen but at the end of the corridor turn left and go outside, down the hill past the bike shed and turn right. The library is in the William Kerr building across the car park.
- **Cripps Postgraduate Medical Centre** (PGMC – Area J), opposite the library.
- **HR** (Area Q), leave the ED via reception, turn left and head down the hill. The sandstone coloured building at the bottom on the right is the old nurses' home, HR is on level 1.
- **Simsuite** (Area Q), as for HR but on the ground floor, turn left and left again, past resus services.

Who's who?

There are many challenges when coming to work in a new trust. One of these is identifying staff. Hopefully this will help you to decipher "who's who". Phone numbers are available on the phone maps, or ring switchboard and say the staff members name to the automatic operator.

Medical team

Lanyards

Across the trust medical staff wear coloured lanyards to denote their grade. These are:

Dark blue	Consultant
Royal blue	Associate specialist
Light blue	Registrar/higher trainee
Brown	Speciality doctor
Yellow/orange	SHO/Core trainee
Purple	FY2
Green	FY1

The ED medical team is as follows:

Consultants

All based in the office adjacent to the main waiting area.

- **Fiona Poyner**, ED Consultant, Divisional Director for Medicine & Urgent Care
- **Tristan Dyer**, ED & PHEM Consultant, Clinical Director for Urgent Care
- **John Trenfield**, ED Consultant, Head of Service for Emergency Medicine
- **Julia Weatherill**, ED Consultant, Major Incident lead
- **Tom Odbert**, ED & PHEM Consultant, Trauma lead
- **Mike Pearce**, ED Consultant, Governance lead
- **Sarah Vince**, ED Consultant, GEM lead
- **Lakshmanan Subramanian**, ED Consultant, Paediatric lead
- **Steve Corry-Bass**, ED & PHEM Consultant, Joint Education lead
- **Jamie Sillett**, ED Consultant, Joint Education lead
- **Kieran Joshi**, ED & ACC Consultant
- **Michael Blumenthal**, Locum Consultant in Emergency Medicine
- **Rachel Jones**, Locum Consultant in Emergency Medicine

Consultants are present in the department 0800-2300 weekdays and 1000-2200 at weekends. Outside these hours they are on-call and will return to the department if required, in line with the Consultant call in criteria (available on the ED pages of the intranet).

Junior doctors

There are many terms used to describe doctors who are not Consultant level. Generally, at NGH you will hear the terms Registrar/Middle Grade & SHO used. Although these are not current terms, they are well understood. Both the registrar and SHO rotas comprise a rolling pattern providing 24/7 cover.

Nursing team

Grade	Uniform	Notes
Matron	Navy tunic / dress - purple piping	Michelle Coe & Keera Neeson are the ED Matrons
Band 7 Sister / Charge Nurse	Navy tunic / dress - white piping	Rhiannon Baker & Kim Paterson are the Adult ED Nurse Managers. Kerry Marriott is the Paeds ED Nurse Manager.
Practice Development Nurse	Navy tunic / dress - green piping	Claire Rush is our ED Practice Development Nurse
Band 6 Deputy / Junior Sister / Charge Nurse	White tunic - navy epaulettes	Male staff
	Striped blue / white tunic / dress - navy epaulettes	Female staff
Band 5 Senior Staff Nurse	As per Staff Nurse but with pale blue epaulettes	
Band 5 Staff Nurse	White tunic - striped blue / white epaulettes	Male staff
	Striped blue / white tunic / dress	Female staff
Healthcare assistant (HCA)	White tunic	Male staff
	Pink tunic / dress	Female staff

Each shift will have at least 1 band 7, often they will be the nurse-in-charge of the shift. All our band 6 & 7 nurses are very experienced and can advise you on local policies if you are unsure.

The majority of our HCA's can perform 12 lead ECGs and undertake venepuncture & cannulation. Most of our nursing team can administer IV medications. If you are asked to assist then please do, remember that these are extended skills for our non-medical colleagues.

Other clinical staff

Advanced Clinical Practitioners (ACP)

Wearing Maroon scrubs our ACPs and trainee ACPs have undergone extensive training at master's level beyond their initial nursing or paramedicine degree to enable them to autonomously assess, treat (including prescribe medications) and discharge patients. Trainee ACPs may ask you to request X-Ray / CT investigations, or prescribe medications for them if they have not completed these modules. ACPs cover extended daytime hours 7 days / week.

Emergency Nurse Practitioners (ENP)

Our ENP colleagues manage the majority of minor injuries patients autonomously. They can be identified by their grey scrubs. You may be asked to assist them in patient management; equally if you are unsure on how to manage a minor injury or fracture, they have a wealth of knowledge and will be very happy to help you. Minors runs a dedicated service 0800-2400 daily.

Streamers

Wearing turquoise scrubs they will be in streaming or majors lite.

Pharmacy

Siobhan Abrahams is our Advanced Pharmacist who works across the Urgent Care directorate. You will often see her in the ED, or you can bleep her on 1917.

Non-clinical staff

Most staff are based in the shared office adjacent to the main waiting areas.

- Jonathan Loasby – Directorate Manager (Urgent Care)
- Kiely Hilyard – Assistant Directorate Manager (Urgent Care)
- Rosie Riddell – Operational co-ordinator / Administration manager
- Debbie Welsh & Emma Pycroft – ED Secretaries
- Karen Ball – Junior Doctor & Rota co-ordinator

Trackers

Each shift will have a tracker; they are based at the nurses' station and use the PC in the corner near the door to paeds ED. They liaise with the site team to organise beds for patients who require admission and are focussed on patient flow through the department. They may ask you about the plan for a patient you have seen. Remember they are non-clinical staff so are looking for a process answer such as if the XR shows … then … otherwise … as opposed to a full clinical management plan. Depending on what you are waiting for they may be able to facilitate this.

Receptionists

Based at the main entrance to the ED they do a vital job in booking patients in and confirming GP / Next of Kin details. They can also arrange for the main hospital notes for a patient if you need them. Depending on the time of day this usually takes about 20 minutes.

Porters

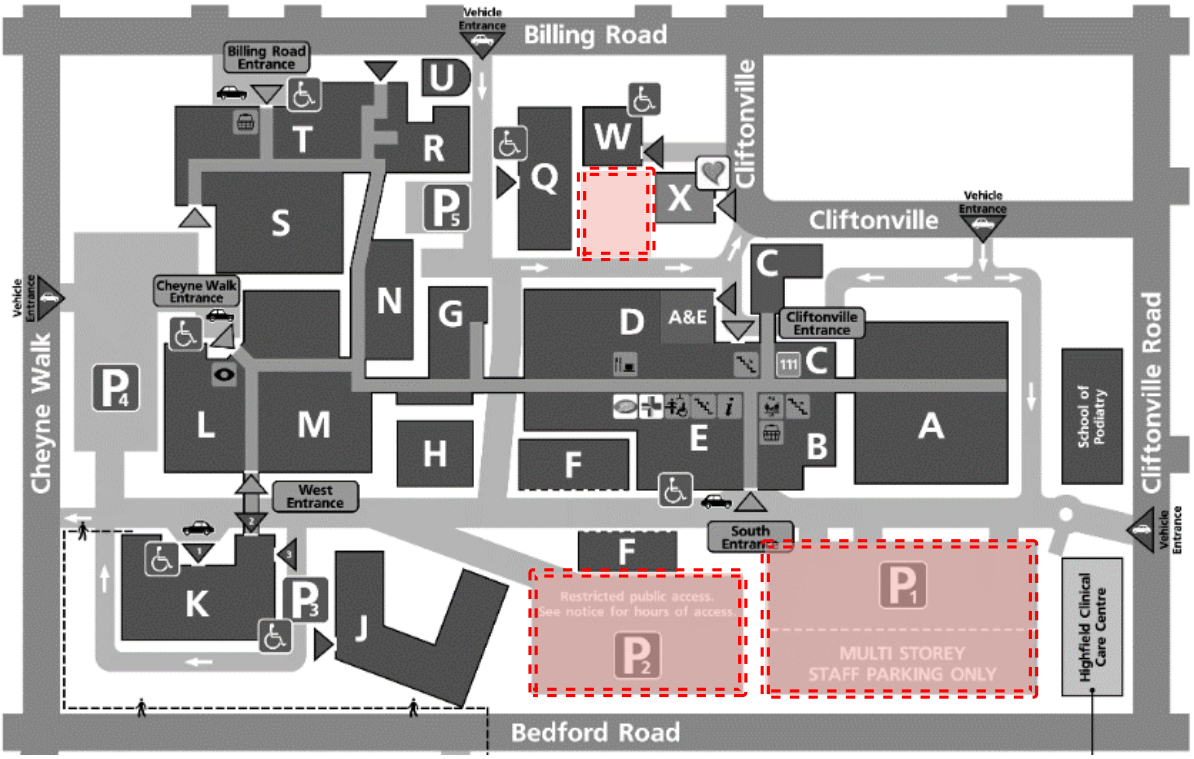
Based near the main nurses' station, they wear blue polo shirts. There is also a clipboard on the nurses' station with a list for patients who require transport to x-ray. Please add your patient to this list after you have requested the x-ray and the porters will arrange with the nursing staff to take the patient to x-ray.

Hosts / Hostesses

Wearing maroon polo shirts, they do regular food / drink rounds of patients and relatives.

Parking

If you would like to apply for a parking pass you need to contact the Travel Office (between Café Royale and Becket ward / Chest clinic). It is generally possible to get a non-barrier on site pass without too much trouble. This will allow you to park in Car Parks 1, 2 and the parking area adjacent to area Q (see below).



Dress code

The full trust uniform policy can be found on the intranet. Read this before you start!

Key points to be aware of are as follows:

- Green ED scrubs can be borrowed from the ED office, £15 deposit per pair (returnable on return of the scrubs in a satisfactory condition)
- Footwear should be black if wearing scrubs
- If wearing your own clothes then you should be 'smart' i.e. no jeans / trainers etc...
- To facilitate hand hygiene, no wrist watches or stoned rings
- Lanyards / ties should be tucked in when involved in direct patient care and hair should be 'off the collar' (this is as much for your own safety as anything else)
- ID must always be worn
- Do not travel to / from work in scrubs (changing facilities are available).

Health & welfare

Critical incident debrief

During your time with us there will inevitably be major cases or incidents which upset you. This is a normal human reaction and does not detract from your abilities as a doctor. Where possible we seek to undertake a 'hot debrief' immediately after the incident.

If you would like to discuss an incident further your first port of call should be the Consultant on duty at the time, if they are unavailable your supervisor or any of the ED consultants or senior nursing team will be happy to chat – just ask! The trust also has a critical incident debriefing team, contactable via the resuscitation service, again just ask. Alternatively you can speak to your own GP.

We cannot say this enough; it is no trouble to talk to you about a case that you found difficult / challenging. All of the Consultants have had emotionally challenging cases during their careers (some more than others). You will be the same, and we are all very happy to chat through cases with you - just ask! We may have said this before, but if something was tough – talk to someone.

Mary's wellbeing room

Adjacent to the staff room is a wellbeing room, named after one of our Staff Nurses. You can use this room if you need a few minutes of rest to reset your mind and relax.

Occupational Health

Located in Area W Occupational Health can offer advice and support in relation to vaccinations, work related injuries / stress, pre-employment screening, sharps / blood exposure and workplace adaptions. Any conversations you have with Occupational Health are confidential and details are not shared without your consent. Crucially, this includes your contact details, if any of your details change then you need to contact Occupational Health separately as they won't receive an update from any of the other hospital departments.

GP

If you are new to the area you will need to register with your local GP, more information is on the NHS website at www.nhs.uk/using-the-nhs/nhs-services/gps/how-to-register-with-a-gp-practice/.

Personal safety

Emergency Medicine is unpredictable; on occasion you will find yourself seeing a patient who is violent, aggressive or agitated. Where possible we will seek to warn you prior to you seeing the patient, either through direct conversation and/or Symphony alerts. However, we need you to be vigilant to such situations also. Ensure you are always aware of the location of the Emergency buzzers in any bedspace you enter, and where possible put yourself between the patient and the door. Inform senior staff prior to seeing a patient who is known to be agitated, and consider using the dedicated mental health rooms (FIT5 & COA1) – both are anti-ligature, have 2 exits and red panic strips throughout.

Security can be reached via switchboard or **2222** in an emergency.

Blood Borne Viruses (BBV)

We have a plentiful supply of gloves, aprons, masks, goggles, and gowns. You must ensure that you use all appropriate measures when involved in any exposure prone procedure. Furthermore, sharps bins are available throughout the department. You are responsible for the disposal of your own sharps, we expect you to challenge anyone who does not adhere to this.

Should you sustain a sharps injury ensure that you bleed the wound and thoroughly wash it. Inform the doctor in charge of the department, and in working hours Occupational Health; out of hours contact Occupational Health the following day. In all instances a risk assessment will need to be undertaken and you will require your own series of blood tests – typically the first set will be taken in ED. Further details can be found in the trust policy (on the Intranet).

Absence procedure

This is a summary of the full policy which can be found in the doctors' office.

- If you are going to be absent for a shift you should phone the ED team phone (24hrs / day) on **07711 917 564** as soon as you recognise that you are unable to work the shift.
- If the phone is not answered (do not leave a message or text) phone switchboard on **01604 634700** and ask for the ED bleep holder (Bleep **8114**).
- If this fails, contact **01604 545610** (ED Tracker) and ask to speak to the doctor in charge – do not leave a message to be passed on with someone else.

In addition, you should email ed.rota@ngh.nhs.uk & medical.staffing@ngh.nhs.uk (plus St Helen's if GPVTS) to confirm the dates of absence. As soon as you are fit to work, you should contact ed.rota and medical staffing so that your pay remains correct (even if you are 'fit to work' on a day off, you won't be expected to come in but it means your 'sickness episode' will be closed – closing this late can impact your pay). Upon your return to work you will need to complete a return to work form.

Communication

Pigeonholes for post are in the staff room. However, where possible, we prefer to communicate via email. Therefore, please ensure that the secretaries have your up-to-date contact details, including an email address that you will check regularly. In addition, you should ensure you regularly check your trust email. We will also need your mobile phone number for major incident call outs, and (with your consent) so that we can add you to our Vacant shifts WhatsApp group. This is where we post any last minute shifts that are available – e.g. to cover sickness. Other vacant shifts can be found on the Patchwork app, contact Karen for more information.

What's On Calendar

We have a department calendar (on Google) at http://tiny.cc/NGHEDWhatsOn this contains the majority of educational and social events. If you would like the .ical link contact Steve Corry-Bass.

If you are not the intended audience for a training event on the calendar, you are still welcome to attend (in your own time). Please check with the session lead to ensure that there is enough space to accommodate you.

Facebook

For those of you who use Facebook we three closed groups, one for education, one for GEM and one for social events. Most of the staff are members and can invite you if you wish.

Twitter

Many staff have their own accounts, the department account is @NGHEDTeam, we use this for communicating with the 'outside world', not for internal communications.

Rota

You should have received a copy of your rota for the duration of your time with us. If you have any questions, please contact Karen Ball; Steve Corry-Bass is the Consultant Rota lead. Where possible, please email ED.Rota@ngh.nhs.uk, this allows others to pick up emails when Karen / Steve are on leave.

We operate 2 rotas, one for SHOs and one for Registrars, both are designed to provide 24/7 cover and are comprised of a series of different shifts; the duration of the shift will dictate the length of break you are entitled to (see below).

We insist that everyone takes their breaks so that they can rest, eat and drink – the staff room has a fridge/microwave if required. Please discuss break times with your colleagues and the doctor in charge at the start of the shift and annotate the daily sheet accordingly. When you go on your break please ensure that staff are aware, and that plans for your patients are up to date. This is so that we don't disturb you whilst you are on your break. Please note breaks should be staggered and cannot be taken during the first or last hour of your shift.

The rotas currently in operation are as follows.

SHO rota

- A / Early – 0800-1700 (9hrs, 1x 30min break)
- B / Late – 1400-2400 (10hrs, 2x 30min break)
  [The FY1 rota also has a B* shift which is 1400-2200, 8hrs 1x 30min break]
- C / Night – 2200-0830 (10.5hrs, 2x 30 min break)

Registrar rota

- Day – 0700-1730 (10.5hrs, 2x 30min break)
- Afternoon – 1200-2230 (10.5hrs, 2x 30min break)
- Evening – 1545-0145 (10hrs, 2x 30min break)
- Night – 2200-0830 (10.5hrs, 2x 30min break)
- SPA – 0800-1600 (non-clinical shift)

Leave requests

The national Terms and Conditions of Service state that leave may not be taken for shifts which attract antisocial hours supplement, instead you need to arrange to swap shifts with a colleague. They also state that you should submit requests 6 weeks in advance. If a request is submitted less than 6 weeks in advance, we will do our best to approve it.

For ease we have online forms for leave requests and shift swaps, all requests should be submitted using these forms:

- Leave requests - http://tiny.cc/NGHEDLeave
- Shift swaps - http://tiny.cc/NGHEDSwap

All leave / swaps should be considered provisional until you receive email confirmation.

Leave types

Annual leave – typically this is 27 days/year rising to 32 after 5 years service in the NHS. However, you should confirm your individual entitlement with HR if you are unsure.

Study leave – for trainees please ensure you also request leave via the HEE system (Intrepid).

Lieu days – because of the way our rotas are constructed, everyone's lieu day leave entitlement will be different. It is possible to take your lieu day on the bank holiday (subject to other leave that has been requested on that day).

Personal / compassionate / carers leave – the trust has a separate policy in relation to this, speak to us if you need to take leave for these reasons.

Shift swaps

Please ensure that you have the agreement of the other party before submitting a shift swap request. If you are listed as 'Person 2' on a swap form, you will be asked to email ED Rota to confirm that you have agreed to the swap before it can be authorised.

Bank shifts

Most shifts are booked via an app – Patchwork. Consultant shift sign off is also completed via this. If a Consultant is not available, do not sign the shift off on their behalf, instead annotate the daily sheet and the admin team will sign it off the next working day.

Doing extra / bank shifts is entirely optional – and remunerated at bank rates. We will ask if you can cover extra shifts, however, you are not obliged to say yes. That said if you commit to a shift we expect you to honour it. If 2 or more shifts are cancelled at short notice & in quick succession you will be debarred from booking further shifts for at least a fortnight and we will seek an adequate explanation since this can have significant effects on your colleagues & patient safety.

Supervisors

You will receive details of your Clinical Supervisor at induction and should arrange to meet them within the first month of your post. During your initial meeting you will be able to discuss your aims and objectives for your time with us, as well as plan your workplace-based assessments.

Education

A range of educational opportunities exist. Irrespective of your planned future career, we are certain that the wealth of patient presentations you will be exposed to whilst you are with us will be of benefit to you and your future patients.

Induction

There is a trust / corporate induction and a local / departmental induction. Given the evolving situation around COVID-19 & social distancing, this years induction will not involve everyone squeezing into the same room at the same time. Induction will comprise a mixture of videos and an online quiz, and face to face elements. After induction you will be asked to provide feedback. Please be honest, we change the programme each time based on feedback from the previous cohort.

Mandatory training

You will be provided with a list of mandatory training requirements by the Cripps PGMC. Many of the elements will be covered via the trust and local induction processes. For those of you rotating to us from another trust, you may have completed training that can be transferred. The remaining elements need completing during the first four weeks of your employment. The Medical Director's office undertakes monthly checks of mandatory training compliance.

EM:WITs

Each weekday morning there will be a ten-minute mini-teach – called an EM:WIT (Emergency Medicine : Weekly Interesting Topic), on a topic relevant to Emergency Medicine. The folder is kept in the doctors' office if you wish to review previous topics. They are all based around prior Serious Incidents, safety alerts, recent changes in practice etc… If you would like to write an EM:WIT then speak to Jamie Sillett or Steve Corry-Bass who can provide you with the templates and guidance. Certificates of contribution will be provided.

Local teaching

Details are still being finalised, however it will be a mixture of workbook. Face to face sessions and in-situ simulations. Our intention is to provide formal education opportunities at least every week.

Trust / regional

Various staff groups have teaching at a trust and/or regional level. Please double check that we have the correct dates for this at the start of your placement so that we can adjust rotas accordingly.

Shopfloor & post-it learning

In addition to the above, various opportunities will present themselves over the course of your shift to learn from colleagues. As well as capturing these in your own personal learning journals we have 'Post-it learning' in the doctors' office. Jot down your learning point on a post-it note (make sure it's legible!) and stick it to the board. The post-its are scanned and emailed to everyone on a weekly basis, if you want to be added to the mailing list, speak to Tom Odbert.

Workplace based assessments (WPBA)

Trainees have a minimum number of assessments that they are required to complete over the course of their placement. Non-trainees are encouraged to undertake WPBAs also and we have a supply of paper forms for those of you who don't have an electronic portfolio.

There is a sticker chart in the doctors' office so that senior staff know which presentations are required; you are responsible for keeping this up to date.

For non-trainees, it is often valuable to have a record of assessments to demonstrate learning for your appraisal or if you wish to enter training at a later date. We have a supply of paper forms that mirror those on the RCEM ePortfolio that you are welcome to use.

Multi-Source Feedback

If you need to complete an MSF / 360° appraisal all the Consultants are happy to be sent assessment forms, please don't feel that you need to specifically ask. All our emails are in the usual trust format – firstname.surname@ngh.nhs.uk

Management portfolio

Higher Specialist Trainees in Emergency Medicine are required to complete a management portfolio. Again, a sticker chart is in the doctors' office for you to complete so that the Consultant team can assist. You are responsible for ensuring it is up to date.

Quality Improvement Project

The trust benefits from a QI team and puts on regular training sessions on Quality Improvement. These tend to be popular, so you are encouraged to contact them early to book your place. If you need to do a QI project for your FRCEM examination discuss this with your Consultant Supervisor. We have a folder of previous QIPs in the Consultant office that you can look at, alongside a 'to do list' of projects that may be suitable.

Audits

If you wish to do an audit, please contact Tristan Dyer and/or discuss with your supervisor. In addition to the annual RCEM audits, we have a range of local audits that are undertaken regularly. Alternatively, if you have an idea for an audit then please let us know.

A 'typical' day

Whilst there is no such thing as a 'typical day' when working in Emergency Medicine, this should give you an idea of what to expect. We are developing role cards to clarify the expected duties of the various roles that you may be asked to fulfil. If you are unsure, please ask.

0700 Day shift registrars start, discuss with the night registrar and / or nurse in charge as to where you are needed.

0800 Day shift SHOs & Consultants start, handover from the night team will be in the doctors office and is led by either the day shift Consultant or Registrar, interesting cases and learning points can be discussed. On weekdays this will also include a 10-minute mini-teach (EM:WIT).

Night shift doctors need to ensure all patients are handed over and any who have left the department are discharged from the system. A free breakfast is available for doctors who have just done a night shift, go to the main canteen with your ID badge.

1200/1400/1600 Further doctors start, check the daily sheet (in the doctors' office) for allocations, and/or speak with the doctor in charge of the shift. If nothing is written then assume that you are starting in majors.

1700/2230/2400/0200 Shifts finish, ensure that you check all your patients have been discharged from Symphony (and are not in the grey 'Left Department' area). Also, ensure any patients you have in the department (including COA) are handed over.

2200 Night shift starts, handover from the on-call Consultant to the night team will be in the doctors' office.

ECG and Blood gas checking

All blood gases and ECG's that are done in the department require checking for life threatening abnormalities. If the patient is in FIT this will usually be done by the FIT doctor, however at busy times or when a doctor is not allocated to this area you may be asked to check a result. You should review the ECG / gas for any life-threatening abnormalities and sign it to say you have seen it. If there is a significant abnormality you are expected to act on it or hand it over to the clinician caring for the patient.

Symphony

Symphony is the tracking system that we use to manage patients throughout their time with us in the department. You are responsible for keeping it up to date for your patients. Critically, this includes the e-notes (especially management plans and rationale), and coding. The coding screens appear prior to referring or discharging a patient. **Correct coding ensures we can apply the correct tariff to a patient's episode of care. Incorrect coding typically results in an underpayment.** You are responsible for the coding of the patients you have seen. Furthermore, you will be thankful of your colleagues correct coding when you come to complete audits.

Patient management

Depending on your grade there will be a variety of doctors, of varying seniority, that you can discuss management plans with. If this is your first post in Emergency Medicine, then you are encouraged (initially) to discuss all management plans for patients as soon as you have finished seeing them. This is a slightly different process to clerking patients on wards, and the reason for this is the four-hour emergency care standard where we seek to be as efficient as possible with our patients' time.

As a general rule, we would expect it to take you 1 hour to complete management for a patient (history, examination, ordering and reviewing investigations, writing notes, referral & discharge). It is usually possible to see and examine a second (or even third) patient whilst awaiting the results of investigations for the first patient you have seen.

Imaging

X-Ray and CT requests are booked via ICE, imaging is located next to the ED, we have 24-hour access to plain film and CT. CT Head requests that meet the NICE standards for Head injury can be authorised by the radiographers. All other requests will require discussion with a radiologist; in hours there is an advice radiologist in imaging, out of hours via 4ways (contact via switchboard).

Portable chest / pelvis x-ray is available in resus only; imaging should be booked via ICE and then contact radiology (x5642) to ask them to come round.

CT reports should be available within an hour of the scan being performed.

X-rays should be viewed using the dedicated X-ray PCs as they have the higher resolution screens.

Bloods

Most blood tests will be requested in FIT and results should be available on ICE within the hour. If additional tests are required in order to make an ED management decision, then check with the lab as usually an 'add-on' request can be sent and the sample that is already in the lab used.

Blood gas machines are in Resus and the FIT lab.

Referrals

Referral guidance is in the doctors office and on the intranet (under the ED pages). This includes guidance on appropriate first referrals, you are encouraged to review this.

Majors referrals to medicine are 'bleep less', that is the referral is made by clicking the referral option in symphony and selecting 'Medical'. This then puts the patient onto the medical symphony screen. All other referrals (including resus medical referrals) are made by contacting the on-call registrar or SHO. Bleep lists are next to each phone. To access the bleep system, dial 88 then the bleep number (4 digits) then the extension you are calling from (4 digits).

Once a speciality has been bleeped the referral should be made to that speciality on symphony (since that is the time of referral). Onward referral is from inpatient team to inpatient team, not back to the ED.

There is a certain art to making a succinct ED referral, practice what you want to say in your head before picking up the phone. Where possible aim to summarise your key concerns and the reason for admission in 1-2 sentences. You do not need to provide a full history; your notes will follow the patient to the ward / admissions unit. You do however need to provide enough information to allow the person to whom you are speaking to prioritise this new patient amongst the rest of their 'to do' list, and to understand why you are referring a patient to them.

If you find yourself having a difficult conversation, don't argue, speak with a senior.

Prescribing

All ED prescriptions (including Oxygen) should be done on the bottom of the FIT forms.

For TTO medications, during the day this should be done using a Boots prescription (available from the Omnicell). Out of hours, prepacks should be used where possible, otherwise we have a

supply of FP10 prescription pads in the Omnicell. Please also document clearly drug / dose / route / duration / rationale in the notes should there be queries after you have finished your shift.

There is a list of over the counter medications in the doctors' office that cost less than a prescription charge. These medications must not be prescribed, and instead patients advised to purchase their own supply.

Communication

In all instances, please ensure that you discuss management plan(s) with patients and (where appropriate) their relatives. If you are giving timescales, please aim to be realistic.

Safety standards

In order to maintain patient safety, we have the following safety measures. The expected standard is 100% in all instances and should be documented in the e-Notes and via the 'Consultant review' option on Symphony. A senior doctor is any doctor at ST4 level (or equivalent) or above.

- Any child under the age of 1 year must be **discussed** with a senior doctor prior to discharge home.
- Any child under the age of 3 months must be **physically reviewed**, in person, by a senior doctor prior to discharge home.
- Any patient seen by an FY1 doctor must be **physically reviewed**, in person, by a senior doctor prior to discharge home (this includes patient discharges from COA).
- Any patient seen by a trainee ACP must be **physically reviewed**, in person, by a senior doctor prior to discharge home (this includes patient discharges from COA).
- The management of any patient returning to the department within 7 days with the same presentation requires **discussion** with a senior doctor.
- Any case where there is a safeguarding concern should be **discussed** with a senior doctor

Major Incidents

What is a Major Incident?

- A major incident is one which requires an **extraordinary response** from the emergency services and / or NGH
- This could, for example, be large numbers of minor casualties from a bus crash on the motorway or small numbers of very seriously injured patients. Either could potentially overwhelm the service we can provide if they present in addition to our normal patients.
- NGH is usually notified of a major incident by the ambulance service via pre-alert red phone in resus
- They will state that a major incident is declared or major incident standby
- If you are the person who takes the call then fill out the major incident form, (which is on the back of the pre-alert sheet), and follow the instructions on it.

What happens if a major incident is declared?

- Major incident procedures will be activated for the entire hospital, not just the ED
- Extra staff will be called in for all departments /wards and all consultants will be notified

- Switchboard will initiate an automated call out procedure for the rest of the hospital but not ED
- ED will initiate our own call out to contact relevant members of staff via the Alert Cascade system on the computer at the nurses' station. This will be done by the senior doctor/nurse present in the ED at the time (aka 'operational group').
- **Do not** make any independent decisions without notifying the senior nurse / doctor via your team leader e.g. do not move patients from one clinical area to another without express permission from the operational group
- The **importance of vertical communication** (i.e. up and down the chains of command and control) **cannot be stressed enough**. Maintaining this is paramount to the smooth running of the department and the hospital.

What happens to the ED when a major incident is declared?

- As many patients as possible will be cleared from the ED in preparation for the arrival of casualties
- If patients choose to leave they will be given a specific major incident information leaflet
- All patients who choose to stay will be given a unique major incident pack with a unique major incident number and re-triaged according to major incident triage sieve/sort and moved to the appropriate area
- The major incident packs are kept in the triage team box
- All notes will be recorded in the major incident pack and investigations requested don the paper forms in the pack
- Symphony will be used during a major incident in **Majax format**
- Patients will be classed as priority 1, 2, or 3
- P1 patients will be in **Resus**
- P2 patients will be in cubicles **10-19** and **FIT**
- P3 patients will be in the **Urgent Care Rooms** and cubicles **20-26**
- **Paediatric P2** patients will be in the **Paeds area** where possible
- Each area will have a specific team allocated to it and a specific box of equipment / instructions
- The main entrance to ED will be locked, the only way in for patients will be through the ambulance doors where patients will be triaged (according to major incident triage sort) on arrival by the triage team
- When a patient leaves the department a **yellow disposal slip** must be **completed** and sent to **reception**
- The major incident will end at the scene when the ambulance service declare major incident stand-down, this does not mean that it will end in the ED at the same time as we may still be receiving patients.

What happens if I am already at work when a major incident is declared?

- First of all… **do not panic!!**
- You will not be asked to do anything that you do not normally do in your normal job
- You will be assigned a specific role / responsibility in a specific area by the operational group for which you may have a clear set of instructions (aka an action plan)
- **Do not** undertake any other role outside of that which you have been allocated

- You will continue in this role until you are relieved; this may be some time
- Prior to arrival of patients it may be beneficial to eat something if you can and pay a visit to the toilet
- It is very unlikely that you will be able to take a break during a major incident
- If you are not scheduled to work the following day then do not presume that you will be able to leave on time.

What happens if I am not at work when a major incident is declared?

- It is likely that you will be contacted by telephone by the automated Alert Cascade call out system
- You will be required to respond in one of the following ways:
    - I am available to come to work with an estimated time of arrival
    - I am not available to come into work
- The automated system will continue to call you until you respond
- If you are due to work later that day or are on nights then you may not be called at all
- If you are due to work later that day, or are on nights then **please do not attend** even if you are available; this is to ensure the normal shifts can still be covered in the immediate period after the major incident

If I'm available to attend what do I need to do?

- Ensure you have some form of ID as this may be checked to ensure that you are a genuine member of staff and not a member of the press trying to gain access to the hospital
- Check for road closures due to the major incident if driving to the hospital and plan your route accordingly
- Park at the back of the hospital in car pars 1 and 2
- **Do not** drive your car to, or get dropped off at, the front of the ED; this area will be restricted access for emergency vehicles only
- **Do not** present directly to the ED, **you will not be given access regardless of who you are**
- **Enter the hospital via the entrance at Integrated Surgery**
- No other doors will be open as the hospital will be locked down by security when a major incident is declared
- Once in the hospital present to the **ED control team** at the nurses station where your role/responsibility will be allocated

Where can I find out more information?

- The major incident plan for the hospital and the specific plan for the ED is on the Intranet
- Please read or at least look at the plan for ED, preferably before a major incident is declared!
- There are courses regarding major incident management; one of these is called Hospital Major Incident Medical Management and Support (HMIMMS). It is very useful and suitable for all members of staff.
- MIMMS deals with the pre-hospital aspects of a major incident and is useful for medical staff
- RCEM Learning has some good resources on major incidents

- Ask Dr Julia Weatherill, SR Rhiannon Baker, SR Nicole Reid, JCN Matt Friedel or Jeremy Meadows (Head of Resilience)

In summary…

- Major incidents are very uncommon however we all need to be prepared to deal with one
- Ignorance of the major incident plan is no excuse
- We all have a responsibility to be familiar with the plan and have an idea of our likely roles

Lastly

The 6 P's:

Prior **P**reparation and **P**lanning **P**revents **P**oor **P**erformance

Ultrasound

We are fortunate to have an ultrasound machine in Resus 1, and a second machine in the FIT lab (although this machine belongs to the Sim Suite, it is stored in ED when not in use). We run an annual level 1 course, and many of the Consultants can sign off the triggered assessments. If you are using a machine you must ensure that you:

- Only use it if you are signed off, or are being supervised
- Save all images and document clearly in the patient notes
- Look after the machines, plug them in and clean them after use.

Good egg awards

We have weekly good egg awards, if you wish to nominate a member of staff for being a 'good egg' and going beyond what would normally be expected of them fill in a form and put it in the box in the doctors' office.

Tips, Tricks and Tribulations

Finally, a few words of wisdom and cautions as you commence on your ED journey.

- Any woman of childbearing age is pregnant until you have proven otherwise (a negative pregnancy test)
- Any pregnancy is ectopic until you have proven otherwise (a confirmed intrauterine pregnancy – although there are rare cases of a second ectopic pregnancy)
- 'Just drunk' is a diagnosis of exclusion, check capillary glucose, consider head injuries
- Falls in older patients are fast becoming the biggest cause of 'major trauma'
- If a young man or boy presents with abdominal pain, think testicular torsion
- Always think cauda equina and check for red flags with back pain
- Infants under 3 months are septic until proven otherwise
- Regular attenders with chest pain can still have an MI… those with abdominal pain can still have pancreatitis or bowel perforation… etc…
- Non-traumatic joint pain? Think septic arthritis.
- Sepsis is not the only cause of a raised NEWS.
- If you don't understand a seniors' plan, ask! It could be a learning opportunity for us both.

Lastly, some quotes…

- There is no body cavity that cannot be reached with a #14G needle and a good strong arm (The House of God, a satirical novel from the 1970s, and something to reflect on with any penetrating trauma, no matter how innocuous the entry site looks).
- You won't always have a diagnosis, but you must have a plan (ED Consultant)
- Read your notes back to yourself and imagine saying 'your honour' after every sentence (ED Consultant) – a good way of 'sense checking' a management plan
- Sometimes the delivery of good medical care is to do as much nothing as possible (The House of God) – 'Watch and wait' as opposed to immediate treatment is an appropriate management plan in certain circumstances.
- People will forget what you said, people will forget what you did, but people will never forget how you made them feel. (Various)

And finally, welcome to the ED family! We look forward to getting to know you!