# LMH ED
# Orientation Info for Paediatric Team & Paed-ED RMOs

**Last reviewed/updated: April 2023**

# ORIENTATION GUIDE

# Welcome

### From the LMH ED Consultant Team

For many people the Emergency Department is their first point of contact with the health system. Patients come with a certain urgent need. As such, our role in the ED is to provide optimal assessment and initial treatment and/or advice to any patient with an illness or injury who presents to us.

In an emergency department anything can happen and probably will, at the least convenient time. The patients and presentations you see are often interesting, sometimes stressful, but rarely dull. If you have never worked in an emergency department you may be experiencing some anxiety. This is normal. In addition - there is always a safety net, providing you use it. This is the ED consultant group. If you don't know - ASK!

You will find that successful management of acutely ill patients relies on a team effort. You are never alone in managing a patient but have the support of experienced nursing and medical staff. Feel free to draw on their accumulated skills and insight to further your own diagnostic and management skills. We hope you enjoy your work with paediatric patients in the Emergency Department.

Our Emergency Department Head of Unit is Dr Aman Anand, who has a keen interest in paediatrics having worked as a consultant at the Women's and Children's ED previously. If you have feedback that you feel is appropriate to direct to the ED HOU then feel free to email him at Aman.Anand@sa.gov.au

**We acknowledge that currently working in healthcare is challenging for us all with changes in practice, and the rapid speed at which changes are occurring- the information contained within this booklet is likely to change despite our best efforts- keep an eye on your emails for updates as they occur!**

**ED Paediatric Liaison**

Dr Keiko Morioka, Dr Elissa Pearton, Dr Hannah Green and Dr Sean Tay are ED consultants at LMH and act as liaisons with the paediatric team and as supervisors for the paediatric-ED RMOs. If there is a need to escalate problems, then feel free to contact them directly, or via the Paediatric Senior Registrar.

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## Areas of the LMH ED

The LMH Emergency Department is divided into several different areas with different functions. We are currently undergoing a redevelopment so things can be a little tricky (and noisy) at times. Please ask if you cannot locate the paediatric-specific equipment you require.

## Triage and Paediatric Waiting Room.

All patients are seen on arrival by a senior nurse based at triage. They make a quick assessment and give them a triage score of 1 - 5 which is a scale of urgency. Patients are triaged to the resus rooms (R- 01, R-02, R-03, R-04, R-05 on the Sunrise tracking screen) or to elsewhere in the department.

NALHN ED policy is that children under 28 days of age (corrected) should have a triage category 2 as a minimum as an acknowledgement that they are higher risk for many conditions and can be challenging to assess. These children may be initially assessed by a senior emergency clinician and sent straight to the paediatrics area (without a full workup) if it was deemed safe and appropriate.

## Resuscitation Rooms and patients.

There are multiple fully equipped resuscitation rooms, in which radiology and all procedures can be performed. Patients in these rooms are managed by the "resus team". You may hear an overhead page "paediatric resus to resus". You are not required to attend these; however, we encourage you to attend if you are available, as you may both benefit from this learning experience, and be of assistance to our sicker patients. If there is a category 1 paediatric patient, they will mainly be looked after in one of these rooms. At no point is it intended that you manage a sick patient in the resus room on your own – if you feel out of your depth, please call for help!

Resus 1 is our isolation/negative pressure resus room and so preferentially those patients who have COVID/suspected COVID or high risk for COVID and require aerosolising procedures are placed in this room.

There is a system in ED by which all paediatric triage priority 2 patients are meant to have an initial assessment in Resus, this is flagged by an overhead call "Paediatric Priority 2 to Resus". If you are free, and the paediatric area is settled, it would be much appreciated if you could attend to the Category 2 patient. The resus team doctors may ask you to assist and see that child if you are able. This will likely be the case if there are multiple concurrent resus cases occurring or a particularly aggressive adult patient has arrived in resus and the paediatric patient is stable and should be stepped down from resus sooner rather than later.

A Cat 2 paediatric patient may then require ongoing treatment in resus or may be stepped down to the main ED. Quite often the child is stable, and does not require resus intervention, then they may be rapidly stepped down to the main department where any available doctors should be able to see and manage the patient directly or take over care of the patient. The priority may not have been changed on Sunrise but not infrequently patients are considered 'downgraded' when they are directly placed into the main department.

If the Resus team doctor has seen the patient and has put their name on them- then they should continue care. If you are unclear about who is looking after a child, please ask someone to clarify; the consultant covering resus (see ED daily staffing list) should have some insight!

## The Main Department

ED has multiple areas these are as follows:

- **T Zone** is made up of cubicles T-01 to T-31 *("Majors" patients are streamed to T-01 to T-16 and "Minors" patients are streamed to T-17 to T-31)*
- **Q zone** consists of 10 cubicles Q-01 to Q-10 (2 rooms are seclusion rooms without monitoring and there are only curtains dividing the other cubicles). This is primarily an ambulance off-loading zone, though has enough flexibility to be re-purposed for department needs and flow (e.g. several cubicles may be used for admitted patients)

- **P zone** is the new paediatric area- currently 8 cubicles P-01 to P-08. There is a Paeds Procedure Room within this area, with most commonly used equipment, including supply of nitrous oxide for procedural sedation *(by appropriately trained senior medical/nursing staff)*. There is a separate paediatric waiting room attached directly to this area, visible to staff in P.
    - The paediatric area has its own clean and dirty utility rooms as well as bathrooms including shower/bath for patients.
- **Resus** is R-01 to R-05. R-01 is an isolation room.
- **U zone** is the Emergency Extended Care Unit (EECU). Note this is only for adult patients.

## Nurse Practitioners

Our ED nurse practitioners see many paediatric cases, including minor traumas and simple ENT/skin issues. They are another valuable resource to consult, especially in managing children with minor injuries. They are located in the S Zone, just adjacent to T-minors.

## Emergency Extended Care Unit (EECU)/ U Zone

LMH ED has an EECU which is an inpatient unit run by the ED consultants and under the care of the ED director. Patients can stay there for a maximum of 24 hours from the time they present to ED, and so it is used for those presentations where this is appropriate. All admissions must be discussed with the ED consultant prior to going to the unit.

At times it may be appropriate for teenagers to be admitted to EECU, and this can be discussed with an ED consultant at that time. Sometimes those aged 16 and 17 (potentially younger) are more suited to the adult department- again please discuss with the consultant at the time.

## Ward-based Paediatric Short Stay Unit.

There is no paediatric short stay unit within LMH ED. This activity occurs on an area of the paediatric ward which also functions as a short stay unit, enabling patients who require only a few more hours of treatment to be admitted to a ward space whilst completing their assessment or treatment. This is overseen by the paediatric team, but ED should suggest patients as short stay admissions when referring them to the admitting registrar. This is advocated as a space for observing children who just need a little longer in terms of ensuring normalisation of observations, need a urine sample and this has not been obtained yet in ED, stretching with their salbutamol dosing etc. When you refer for a short stay admission, BE SPECIFIC about what you think needs to happen, make sure you have a documented provisional plan.

# LMH ED Redevelopment

Works are ongoing as part of the ED redevelopment project which is a part refurbishment of certain areas of ED along with an expansion. This will have a significant impact on the whole department and will do until work is completed in late 2023. Building is ongoing and may intermittently impact on the functioning of ED in terms of noise and the presence of builders etc. This work will result in a reduction in the available cubicles for assessing patients and hence on the function of the ED.

# General Information

## Resources

The department has a wide range of resources that are available to you during your attachment. These include clinical guidelines, IT platforms and textbooks. In addition, of course you should make full use of the vast experience of the clinicians you encounter. Some clinical textbooks and resources (e.g. uptodate) will be available via SALUS, which you can sign up to for free to access these from your own devices without the intranet.
SA Health has a number of paediatric specific guidelines that are statewide. There are also local NALHN guidelines, or the WCH has a large repository of guidelines for that network, some of which are relevant to LMH. Some examples:

Only available via intranet (i.e. SA health computer):
NALHN guidelines (via PPG link) – some useful ones include capillary blood sampling, intraosseous needle insertion, NGT insertion, as well as clinical guidelines (with handout with local numbers).

Available freely

1) RCH (Royal Children's Hospital) clinical guidelines (also app is available)
   Clinical Practice Guidelines : About Clinical Practice Guidelines (rch.org.au)
2) SA paediatric clinical practice guidelines
   Paediatric Clinical Practice Guidelines | SA Health
3) QLD paediatric resuscitation tools
   Paediatric resuscitation tools | Queensland Paediatric Emergency Care (health.qld.gov.au)
4) Monash paediatric emergency (resuscitation) medication book
   Print the Paediatric Emergency Medication Book - Monash Children's Hospital (monashchildrenshospital.org)

1 is available as a free app; 2/3/4 are extremely useful to keep on your phone, too. There are only limited local (SA) guidelines available yet but there are additions occurring regularly so keep up to date!

## Departmental Handovers

These occur at 0730 for the ED night team to day team and at 2300 for the late team to night team. Separate 'Area' handovers occur between the ED consultants when they handover between 1500-1530 and then the junior medical staff at 1700-1730 prior to the end of the day shift. This means if you are working the late shift from the ward, you miss the departmental handovers. Please involve the ED consultant in the relevant area in any handovers if there are issues, concerns, or questions regarding patients.

## Sick Leave

If you are sick or unable to work your shift for any reason then contact the duty ED Consultant on 8182 9512, or if calling after midnight, the night Senior Registrar on 8282 1290 as soon as practical. The ED consultant phone should be diverted to the night Senior Registrar phone overnight, so call this number if in doubt! Alternatively, on Monday to Friday, during office hours, you can contact the ED medical management facilitator 8282 0283 if this gives adequate notice before the start of your shift. It is also worth letting the paediatric team know if you are sick for an ED shift as this will likely impact on the ward registrar.

There are separate guidelines via NALHN which give the process which you need to follow if you have tested positive for COVID or are considered a close contact with a COVID positive person.

## Medical Documentation => SUNRISE

LMH ED has started using 'Sunrise' an EMR to document medical assessments as of August 2022. You will therefore need Sunrise training prior to starting at NALHN, if you haven't previously. Always ensure you clearly document your provisional diagnosis, results of any investigations, management plan for the patient and their clinical progress with final diagnosis and disposition. This provides a summary of the patient and is critical for ensuring other staff members understand what is happening to the patient. Please also remember to ensure they are dated and timed (Sunrise does not do this automatically so it is important to track what happened for the patient- particularly in the progress notes section of the EMR ED document).

In the interim phase, whilst many patients still have significant records on paper you may still require access to patients' clinical records to clarify previous presentations etc., please speak to ED admin staff to gain access to these.

## Oacis

As there is currently not an alternative for aspects of Oacis used at NALHN, this remains the method for referral to certain OPD services from ED (particularly Orthopaedics Fracture Clinic).

## Advocacy

If you have any concerns with the assessment process or any concerns at all during your term, then you should address them with your term supervisor. Otherwise Elissa, Keiko, Hannah or Sean are the ED consultants involved with the PED and liaise regularly with the inpatient paediatric teams, please feel free to voice any issues or concerns to them in person or by email. If they are not able to help you or for whatever reason you feel uncomfortable discussing a matter with them, then you should approach the ED Director. You can arrange to see them by contacting the ED secretary and asking for an appointment. The alternative is to approach the paediatric senior registrars or seniors within the paediatric department.

At times you may be more comfortable talking to someone outside the department. The medical education officer is very happy for you to approach. Alternatively, you may prefer to talk with the Director of Clinical Training.

Sometimes we experience issues that we just need to talk to someone completely remote to our workplace. You may find the independent confidential employee assistance programs helpful for this. You can find further details via the NALHN intranet page under 'Staff Matters' -> 'Employee Wellbeing' -> under 'Wellbeing resources' find 'Employee Assistance Program'. Current EAP providers are Access Programs (Tel: 1300 667 700, www.accesssa.com.au), Human Psychology (Tel: 1300 277 924, https://humanpsychology.com.au) and Australian Institute for Loss and Grief (Tel: (08) 8341 5557, www.lossandgrief.com.au). You can call any of these providers and identify yourself as a NALHN employee to arrange an appointment.

If you feel that you are being unfairly treated in anyway and your discussions with your supervisors and/or the medical education unit and any actions that they may have taken have failed to resolve your concerns, then you have the right to lodge a grievance against the relevant party and have the matter independently evaluated. The human resources department of NALHN are best placed to advice on this process.

## ED Consultant Staffing

Below is what the ideal consultant staffing should look like:

- AM *0730-1500*:
  - 1 x ED consultant covering T zone Majors *(Ext: 29787)*
  - **1 x ED consultant covering T zone Minors + P zone *(Ext: 21291)***
  - 1 x ED consultant covering Resus with 2 Mos *(Ext: 21293)*
  - 1 x ED consultant covering EECU/U zone ward round with 1 x intern *(Ext: 29512)*
- PM *1500-0000:*
  - 1 x ED consultant covering T zone Majors *(Ext: 29787)*
  - 1x ED consultant covering T zone Minors *(Ext: 21291)*
  - 1 x ED consultant covering Resus with 2 MOs *(Ext: 21293)*
  - **1 x ED consultant covering P zone, Q zone + Waiting Room *(Ext = 29512)***

At times the department may be short-staffed for ED consultants, this means that when there are only 3 consultants on the AM, 3 consultants on the PM and a "P12" consultant to cover resuscitations between 1200 and 2100, the T Zone Minors Consultant will also cover resus until midday. On the late shift, the consultant covering the P zone also covers the Q zone and assists in 'upfront' assessments at triage so may be elsewhere than paediatrics depending on activity.

## Your responsibilities at LMH ED

Your responsibilities are to see and manage paediatric patients arriving in the LMH emergency department. This involves the following:

- Primary assessment and management of paediatric patients presenting to ED.
- Streamlining admissions from the ED to children's ward. This is in liaison with the paediatric registrar working on children's ward, either referring to them as the Paeds ED RMO or if you are part of the paediatric team, liaising with your ward colleagues.

- Your clinical supervisor is the ED consultant in the area you are seeing patients within.
- **There is <u>NO EXPECTATION</u> to manage every paediatric patient in the department or to also supervise the paediatric RMOs if you are a paediatric registrar on an ED shift. The ED consultants are there to supervise and discuss cases. If you are keen and comfortable in discussing some cases, particularly if they are clearly requiring admission then you are welcome to do so but know that there is always a consultant who can be utilised for this. Please feel more than free to remind the RMOs to discuss cases with the consultant!**
- Most commonly the ED team will refer patients requiring admission to paediatrics to the paediatric registrar covering the ward via the pager.
- As mentioned in the resus section- if you are free then the ED Resus Team are often grateful for your assistance with the category 2 (or 1!) paediatric patients triaged to resus.

## ED-Paediatric RMOs

There are 2 RMOs every term who work as ED-Paediatric RMOs, under the supervision of Dr Keiko Morioka, Dr Hannah Green, Dr Elissa Pearton and Dr Sean Tay. They work mostly PM shifts, and once a fortnight they work the AM shift. They also have a specific protected teaching time once a fortnight when one works the AM and one the PM shift, and they both have teaching from 1400 until 1700 (and so are not in ED for this time). The doctor who has been on the AM shift will need to hand over at 1400 so they can try and make it to teaching as close to 1400 as possible – we allow time for handover but it is really appreciated if you are on time to allow this to be as efficient as possible.

## ED Electronic Tracking System: Sunrise

You should have received training in Sunrise prior to commencing at LMH. If you have not received training this needs to be arranged ASAP via your department.

Please note that patients who are triaged to the Resuscitation Bays are likely to have paper Resuscitation Records, Medication Charts and Nursing Notes – these will be scanned in at some point.

## Requesting Tests and Results

*<u>DO NOT</u> ask patients to phone the ED for results of investigations. If a patient rings for a result do not give the result over the phone – you have no way of confirming their identity on the phone. Direct them to see their GP and arrange for the laboratory or radiology department to forward a copy of result to the GP or to check their/their child's My Health Records.*

In the ED, try to only order investigations for diagnostic confirmation of clinical impressions affecting admission or immediate treatment. If the patient does not need to wait for the result the test should not be performed in ED. Ensure you check all biochemistry and haematology test results before the patient leaves ED. This is required medico-legally.

If you order tests where the result is delayed (e.g. swab or urine cultures), follow-up of the patient by the GP or in OPD must be arranged. Ensure you arrange a copy of the results to be sent to the GP and ensure that you notify the GP that this follow- up is required. At LMH ED, if you are sending a culture for patient who is being discharged, you should use the result follow up folder in the P zone so that you are part of the follow up team (including GP.) This results folder is reviewed regularly by the 2 Paed-ED RMOs who do a term solely seeing paediatric patients within our ED – they will ensure that results are appropriately followed up and communicated on to patients/parents and GPs or other clinicians as required.

- Carefully consider whether any imaging inclusive of x-rays is required – there are very few indications for an AXR in a child, and we will at times order too many CXR, so think and potentially discuss before you request!
- ECGs must be first checked and signed by an ED Senior Medical Officer / duty Consultant.

- **Add on tests:** Phone add-on tests are not permitted. Complete an "Add-on" request on Sunrise and call the pathology lab to confirm their receipt of this request.

All pathology specimen containers must be labelled with the patient sticker. Also, you must write your surname, sign it, and the date and time the specimen was taken on the sticker. For specimens going to the transfusion lab, the relevant box on the request form must also be signed by the requesting MO and a witness who has checked the blood matches the patient identification.

## Referral to Outpatients

Many patients should be referred to their LMO/GP for follow up or referral for consultant opinion. However, at times it is necessary to refer directly to outpatients.

- **Fracture Clinics** referrals are currently via Oacis

- **Paediatric Rapid Access Clinic** is booked with a paper referral into a specific tray labelled with the clinic name. These referrals should be discussed with the paediatric registrar prior to ensure the case is appropriate for the clinic (it only occurs on Fridays, and has limited slots, staffed by one consultant and one RMO).

- **LMH or WCH general paediatrics**
  Require a written consultation form completed and left with our clerical staff to process with your case notes. Ensure the correct address and contact telephone number of the patient is on the consultation form. **Please ensure you write LMH or WCH at the top of the form.**

Outpatients will contact the patient with an appointment time. Ensure correct address and contact telephone number of the patient. In general, referral to OPD from ED is DISCOURAGED (with a few exceptions such as fracture clinic), as our referral is only valid for 2 months. So, you should encourage the patient to see a regular GP to get a referral which is valid for 12 months, in addition to providing ongoing management for the patient.

## Telephone Advice

No medical advice may be provided over the phone under any circumstances. The department receives many phone calls requesting advice and it is tempting to try to offer a possible diagnosis or offer medical advice. Your response should always be polite but firm with something like the following "I am not permitted to provide telephone advice. If you are concerned you may come to the Emergency Department, contact your General Practitioner or use HealthDirect".

## HELP! Or ways to escalate clinical concerns

If you need assistance, there are several options. For non-urgent discussions/assistance with anything – the ED consultant can be reached by the DECT phones listed on the daily lists.

If there is an emergency or a patient you are concerned about and/or require rapid assistance, please push the red emergency call bell/buzzer – you will generally have a team of senior emergency staff arrive promptly to assist.

There is also an overhead call within the ED which is the departmental version of a Code Blue or MET call – this is called a 'Critical Response Team' or CRT. Nursing staff can call this overhead (dial #883 to announce overhead in the ED). The expected response is the resus medical staff and nurses to attend, but if this team is otherwise engaged with treating an unstable patient, there should be escalation to another consultant/senior ED MO to assist and likewise, escalation through nursing for additional staff to assist as is required. There are criteria for calling CRTs which are placed around the ED, one of which is that if you are concerned, then you should call a CRT – this leaves it open to clinical expertise, the observations may technically be ok but the patient may look more unwell than these

suggest. A paediatric Code Blue can be called for cases within the ED, although this is infrequent and usually the internal equivalent of CRT is called as the alternative.

Nursing staff can liaise with the nursing shift or flow coordinators with regards to needing to have increased nursing resources to assist with managing an unwell paediatric patient, e.g. if urgent IV antibiotics are required and there are no nursing staff available to locate and prepare these. If you have concerns this is not occurring, please escalate via the ED consultant.

In addition, there have previously been issues with difficult IV access in paediatrics and escalating for assistance with this. Please alert the ED consultant if there are major difficulties. If the child is big enough, an ED MO who has experience with ultrasound guided cannulation may be able to assist (this is increasingly less helpful for smaller children due to probe size etc). If the child is more unwell, then intraosseous access can always be considered (though an ED consultant should be made aware of such patients and they should probably be managed in resus).

## COVID-19 and working in LMH ED

### COVID ED staffing

As with all units- the ED has had to change to be flexible with regards to staffing at this time. The main changes have been attempting to stretch our existing ED staff over a broader area.

- IN PRACTICE, this means that the ED consultant that you approach to discuss patients with depends on where in the department you see a patient. But the plan is that it will primarily be the consultant nominated to cover the P zone – T Zone Minors consultant until 3pm and then the Safe-T consultant. Please ask a consultant if you are not sure who this is.
- However, the ED consultants may be flexible with this in terms of which patients they will discuss.
- In general, resus patients will be supervised by the resus consultant.
- Overnight staffing is unchanged, with one ED night TL (who is an ED registrar generally post-ICU/anaesthetic experience) and 6-7 RMOs and registrars.
- The changes may make it more challenging to locate the consultant who is covering the area within which you have seen a patient, please feel free to use the phone numbers on the daily lists throughout the department to contact the consultant you require.

### PPE and Fit testing

We endeavour to make appropriate PPE available in all areas of the ED. If you find this lacking, please escalate to nursing staff in that area.

Please follow the latest PPE matrix for specifics of what is required when. Ensure you are familiar with appropriate donning and doffing of PPE.

Make sure you have been fit tested to a N95 mask that is currently available within the hospital. Please ensure you have checked with your line manager or medical management facilitator and arranged to have a fit test with staff health if you haven't had one.

### Aerosolising procedures

If your patient requires an aerosolizing intervention *(in paediatrics this is most often nebulized medications but may also be a requirement for humidified high flow oxygen)*, then they need to be in a room which has negative pressure capabilities. Please escalate to ED consultant and ED nursing seniors to ensure your patient is relocated as is clinically required to enable this can occur safely.

### Changes in the ED response to COVID

The situation around coronavirus has been changing rapidly and will likely continue to do so. Ensure you are up to date with regards to changes from bulletins through NALHN and from the ED HOU or COVID lead. In short, check your emails!

Remember that in a pandemic, you need to keep yourself safe, so ensure you are adequately protected with the required PPE prior to attending to a patient.

**COVID swabs/testing.**

There are currently 3 types of COVID test.

1. **Rapid Antigen Test (RAT)**
    a. A bedside test with results available in 15 minutes (documented on paper form, copy kept in patients notes, note placed on Sunrise to flag negative/positive)
    b. A screening test, NOT diagnostic test.
    c. If positive, an accompanying COVID PCR test also needs to be requested.
    d. In many cases the RAT is being utilised as the test of choice prior to transferring patients inter-hospital, this is not a situation when GeneXpert should be used.
2. **GeneXpert (rapid test- results available in 1 hour)**
    a. NALHN has a limited supply, each LHN is given fixed number of cartridges per week.
    b. Only indicated for a defined set of indications
        i. See most recent NALHN update- currently GeneXpert is for patients:
            1. Requiring urgent non-invasive ventilation (BiPAP, CPAP, HHFNPO)
            2. ICU patients with undifferentiated severe respiratory disease
            3. Emergency patient with severe respiratory disease or undifferentiated sepsis
            4. Women in labour who are suspected to have COVID or meet current clinical criteria or are close contacts.
    c. Needs to be authorised by a consultant (ED consultant, ICU consultant, Paediatric on call consultant, Respiratory on call consultant, division of medicine on call consultant, ID consultant on call)
    d. Requested on Sunrise as “Rapid Coronavirus-2019 NAT Swab (Consultant Approval Required)”.
3. **COVID PCR test**
    a. The standard swab which takes 24-36 hours to be reported (may be shorter/longer turnaround time depending on demand etc).
    b. Requested on Sunrise as “Coronavirus-2019 Only Screen NAT Swab”
    c. Younger children will more likely be suitable to have general resp swab (“Respiratory Pathogens” swab), which include COVID-19