



POLICY ON COMPONENTS OF AN EMERGENCY MEDICINE CONSULTATION

1. PURPOSE AND SCOPE

- 1.1. An emergency medicine consultation is a complex structured process of significantly variable length depending on the complexity of the patient. The purpose of this policy is to document the components of an EM consultation.
- 1.2. The purpose of the emergency medicine consultation is to maximize patient benefit, whilst minimizing delay and inefficiency in the patient journey.
- 1.3. This policy is applicable to emergency departments and emergency services in general
- 1.4. This policy does not apply to requests for telephone consultations (P44 Provision of Emergency Department Telephone Medical Advice)

2. POLICY CONTENT

The following components will apply to every emergency medicine consultation.

3. PROCEDURES AND ACTIONS

For each episode of care provided by an Emergency Department the following tasks should be completed.

3.1. Pre-arrival notification

Relevant information received from other care providers will be available to triage and senior medical staff within the ED within an hour of patient arrival.

3.2. Triage

Allocate a treatment priority to all patients who arrive for care.

3.3. Initiation of Care

Immediate care will be provided to patients who present with severe physiological and/or psychological disturbance.

Effective first aid will be provided to patients waiting for treatment.

Patients who are waiting for consultation will have their condition monitored.

Early symptomatic treatment will be provided when possible.

3.4. Registration

Obtain appropriate demographic information to enable correct identification of the patient and facilitate subsequent communication with the patient, their relatives and relevant healthcare providers.

The patient's previous medical record will be retrieved for ED staff review.

3.5. Introduction to patient and caregivers

Each patient will be correctly identified.

Each staff member will introduce themselves to the patient and caregivers outlining their role in providing the patients care.

Appropriate staff identification should be easily visible to patients and caregivers.

3.6. History taking

A medical history will be obtained from the patient. The history may be focused on areas relevant to the provision of emergency care.

When required, additional historical information will be obtained from other relevant sources such as: pre-hospital providers, caregivers, residential care facilities, bystanders and the patient's relatives or friends.

3.7. Physical examination

The patient will have a physical examination performed that is relevant to their presenting problem(s).

3.8. Consultation with supervisor

All resuscitation cases will be discussed with the most senior clinician available. This should be an Emergency Physician.

Doctors engaged in junior roles (Interns/RMO/JHO) will consult with the most senior doctor in the ED prior to initiation of a diagnostic and management plan for all patients.

Non medical staff will practice in accordance with delegated authority from the responsible emergency physician.

3.9. Diagnostic and management plan

A diagnostic and management plan will be generated in consultation with the patient, caregivers and the ED staff member's supervisor.

3.10. Investigation ordering

Investigations relevant to the patient's problem may be performed. This may include the establishment of vascular access, blood taking, medical imaging and collection of samples for microbiological or other analysis. Treating ED staff may be required to perform a 12 lead electrocardiograph and to measure blood glucose, haemoglobin, arterial blood gases, and other relevant point of care testing including bedside ultrasound. Results of common non bedside ED investigations, including medical imaging, should be available within one hour.

3.11. Communication with other ED care providers

Communication of the patient's diagnostic and management plan will occur with other relevant ED care providers.

Initial treatment orders will be available to other ED care providers.

3.12. Documentation of initial findings

Initial findings from history and examination will be recorded in the patient's medical record as soon as is practically possible following the initial consultation.

3.13. Performance of procedures

Relevant diagnostic and/or therapeutic procedures will be performed in compliance with relevant infection control standards.

Consent for procedures will be obtained according to standard policies.

3.14. Review of investigation results

Investigation results will be reviewed and recorded in the patient's medical record. An explanation for all abnormal results will also be recorded.

Alteration of the diagnostic and management plan will occur on the basis of unexpected results and be documented (refer to P54 – ACEM Policy on Follow-up of Results on Investigations Ordered from Emergency Departments).

3.15. Review of the patient's condition

The patient's clinical condition will be monitored, at least hourly, by ED staff.

Responsibility for ongoing care will be determined according to the S18 - ACEM Statement on Responsibility for Care in Emergency Departments.

Patients with features of deterioration will be reviewed more frequently by the responsible clinician.

Patients who continue to deteriorate despite intervention will be reviewed by the most senior available clinician.

Patients whose vital signs fall outside predetermined parameters will trigger a resuscitation response.

Review may or may not involve direct patient examination by a senior physician.

3.16. Referral to inpatient unit

Patients requiring consultation from another hospital service will be referred as soon as is practically possible.

The reason for referral will be communicated to the external unit, including whether admission to hospital is thought to be required.

If consultation is to occur in the ED it will commence no later than one hour from the time of referral, regardless of who admits the patient.

3.17. Completion of medical record

The patient's medical record will be completed. It will include a provisional diagnosis, referrals made and details of the patient's disposition destination.

3.18. Explanation of the patient's condition

An explanation of the patient's condition will be provided to the patient and, when relevant, to the patient's caregivers. This will occur in a way that is appropriate to the patient's cultural, language and educational background.

3.19. Reporting

All statutory reporting obligations will be performed.

All relevant medical reports will be provided.

Incidents that caused or could have caused patient or staff harm will be reported.

3.20. Quality, Research and Education

Patients may be asked to participate in quality and research projects, when appropriate.

Patients may be asked to participate in educational sessions, when appropriate.

3.21. For patients requiring admission

The patient will leave the ED within one hour of the decision to admit.

The patient will leave the ED with all appropriate urgent investigation results obtained and initial treatment orders valid for up to 6 hours.

Transfer of the responsibility of care will occur between the ED and inpatient care providers.

3.22. For patients discharged from the ED**3.22.1. Pre-discharge screening**

There will be a screening process to assess patients' suitability and safety for discharge.

A mandatory component of this screening process requires consultation and authorization of this discharge by an emergency physician or a delegate.

3.22.2. Discharge medications

An explanation of the discharge medications provided and their possible adverse effects will be provided.

3.22.3. Discharge instructions

Instructions will be provided to the patient (and or caregiver) of measures to be taken to assist in the patient's treatment, including the timing and service involved in scheduled review of their condition. Instructions as to when to seek unscheduled review will be provided.

Where relevant, written discharge instructions should be given.

Documentation in the patient's medical record should reflect the content of discharge instructions.

3.22.4. Discharge communication

Communication of the patient's diagnostic and management plan will occur with other relevant health care providers.

3.23. Certificate completion

Completion of all relevant certificates will occur prior to the patient's discharge from the ED.