WELCOME
Welcome to the Emergency Department of the University of Washington Medical Center. Our hope is that you will enjoy your rotation here while learning how to efficiently and carefully manage multiple, complex patients and the basics of emergency medicine.

ORCA TRAINING
- At the bottom left you will see the “Clinical Applications Education” link
- On the left sidebar, click “Practitioners”
- On the second page of the ORCA Practitioner Featured Education Material, click the “FirstNet – Overview” link

EDUCATIONAL GOALS
Interns will rotate through general emergency medicine rotations to:
- Develop skills to evaluate and manage patients with undifferentiated illness presenting for emergent evaluation
- Develop skills at dispositioning the undifferentiated patient; demonstrate ability to recognize patients who are severely ill and require admission
- Resuscitate and stabilize critically ill patients
- Learn the mechanisms, clinical manifestations, and diagnostic strategies for patients with common emergent disease states
- Optimize communication strategies to transition patients from the emergency department to the inpatient setting or home
- Demonstrate the ability to manage multiple patients simultaneously and efficiently
- Develop collegial relationships among physician colleagues from all departments
- Learn the appropriate and selective uses of technology and diagnostic studies in evaluation of patients

LEARNING GOALS AND OBJECTIVES
See Appendix I

WORKING IN THE ED
Always think of the ED experience from the patient’s perspective. They are in the ED because something went wrong or became out of control in their life. They don’t want to be here. Part of being a compassionate provider is to give the patient back a sense of control. Please remember to always introduce yourself and let the patient know what to expect during their evaluation (eg. IV, blood work, x-rays, procedures, and expected wait times). Check in on your patients frequently and keep them informed of what is happening in their evaluation.

Expectations: The expectation of the faculty is that you will see one (1) patient per hour, averaged over your ten (10) hour shift (9-10 patients per shift). You will be expected to manage several patients at one time. Avoid the temptation to see one patient, work them up, and document before seeing another patient. You will have limited educational experience and be very bored if you do this. Also, the ED will become backed up and patients will have longer wait times. You should be able to follow 3-4 patients at one time through efficient multi-tasking.

Arrival: You must carry a Spectralink phone while on shift. When you arrive for your shift pick up your Spectralink from the Patient Services Specialist (PSS). When you sign on to FirstNet, go to Provider Check-In to include your name and the last 4 digits of your Spectralink number with your display name. Page consultants and admitting teams to your number.
**Patient Evaluation:** Your focus should be their chief compliant. Sometimes it's helpful to ask them why they came to the ED and how we can help them. Do a brief history and directed physical exam. This should take no more than 10-15 minutes. Then leave the room and order any labs or imaging studies that are appropriate for the evaluation of the complaint. Discuss the case with the attending prior to the ordering of CT, ultrasound, or vascular studies. Once the studies are ordered you may return to the patient’s room to complete your history and physical if necessary. Do **not** spend an hour in the patient’s room, then come out and start ordering tests that will take another hour. Discuss all patients with the attending prior to calling a consulting or admitting service.

**Patient Acuity:** If a patient is hemodynamically unstable or appears seriously ill, let the attending and/or senior Emergency Medicine resident know immediately. When signing up to see a patient, please see the sicker patients first. The acuity level is on the tracking board. The lower the number, the sicker the patient. For example, sign up for the chest pain patient before seeing the sore throat. If all patients have the same acuity level, sign up for the patient who has been waiting the longest. Please make sure you go in the patient room to see them within ten (10) minutes of signing up.

**Orders:** All ED diagnostic orders will be submitted via CPOE. This includes labs and radiology studies. Use ED PowerPlans as much as possible, as they are much easier to use and will mean fewer orders to sign in your inbox. When ordering labs and studies in the ED consider whether the result will change the ED management plan. Generally, if it won’t change management, a lab or imaging study should not be ordered. There will be exceptions but that should be your working approach.

**Procedures:** All non-emergent procedures (LP’s, central lines, chest tubes, transfusions) require a consent form to be completed. Further, the patient should be fully advised of the risks and benefits of the procedure. Lacerations are exempted. All lacerations need length, complexity (simple, intermediate, complex), number, and type of sutures placed documented. Please include procedure notes in your documentation. There are templates for procedure notes in the PowerNote menu.

**Seeing Patients:** You should see patients from the start of your ten hour shift until the end. This means you may not save the last few hours for only documentation while no longer seeing patients. This can create an unfair burden on other residents. Instead, document when you have time, such as when you are waiting for results. **DO NOT** document if there are patients waiting to be seen.

**Documentation:** Use ORCA PowerNote for your documentation. The template “ED Note (MD ARNP)” must be used. This PowerNote will prompt you to include the essential elements of an ED note. You must sign your note to the ED attending as the Attending-of-Record.

**YOU MUST COMPLETE ALL OF YOUR DOCUMENTATION BEFORE YOU LEAVE THE HOSPITAL**

Patient Data Services (PDS) may contact you during your rotation if you have not completed your documentation. If your documentation is then not soon completed, PDS will notify the ED attending. If they remain incomplete after this, the next notification will go to the ED Medical Director, Martin Makela, MD; the Division Head of Emergency Medicine, Susan Stern, MD; and the UWMC Medical Director, Tom Staiger. **Please get your documentation done on time.**

**Sign Out:** Try to complete your patient evaluations and work-ups before your shift ends. However, if a patient is expected to be in the ED for a prolonged period past the end of your shift, you may sign the patient out to another
resident or attending. You should not sign out a patient who requires a procedure or who does not have a reasonable plan in place. Please keep in mind that out of courtesy, you should document your care up until the time you transferred care to another resident. This would include the pending work-up, perceived plan as discussed, and the name of person assuming care. They will be responsible for adding only an addendum and diagnosis. It is not appropriate to see, evaluate, and initiate a work-up on a patient and then sign out the documentation of the entire record of the patient’s visit.

**Schedule:** Your schedule is available on Medhub (uw.medhub.com). Keep in mind that your schedule may be revised or updated. Check Medhub for changes. We make every effort to inform you of changes in a timely manner and with as much advance warning as possible. **Please be on time for your shift!** If you will be late please notify the attending by calling 206-598-0105. This is a professional courtesy to ensure you aren’t sick or hurt.

**Sick Leave:** If you are sick, please notify the EM chief by paging 206-314-8884 so a risk resident can be called if available. In addition, please notify your program administrator and/or chief resident.

**Shift Trades:** Residents are responsible for finding their own swaps if they would like to trade shifts. A shift trade may not violate duty hours for either resident. If you secure a proposed trade contact the EM chief resident, who will review the trade. All swaps must be proposed at least 48 hours prior to the beginning of the shift and approved by the chief resident before they are official.

**ADMITTING A PATIENT**
Before contacting an admitting service, the patient must have been presented to the ED Attending. An admitting service can be contacted through the paging operator at 8-6190 by asking for the admitting resident or attending (Medicine, Heme/Onc) for the desired service. Page to your SpectraLink phone. When an admitting service has accepted a patient for admission, complete the “ED Decision to Admit” order which will fire the “admit Red clipboard” icon on Firstnet. If you admit a patient to the Medicine or Heme/Onc service you will first speak to a triage hospitalist, who will accept the patient and determine which team the patient will be admitted to. Once you know the specific team the patient will go to, you will then need to call the admitting resident for that team.

**DISCHARGING A PATIENT**
The discharge process is done through the computerized FirstNet system. ALWAYS give specific return precautions, not “any problems” or “symptoms worsen”. Specific symptoms might include fever, vomiting, difficulty breathing, or chest pain. The FirstNet discharge process will allow you to point and click on such symptoms. No patient should leave the emergency department without an acceptable follow-up plan. If they don’t have a primary care doctor, they can be given a list of community health centers through the patient education portion of the discharge process, they can be referred to family medicine or internal medicine, or they can return to the ED for reevaluation. If you ask a patient to return to the ED, please include the reason on the discharge instructions. Otherwise it may be unclear to the next practitioner. Correctly completing the discharge process will let the nurse know the patient is ready for discharge via the Firstnet board. Do not print the discharge instructions; The RN will print them and discharge the patient. Discharge “huddles” will be done prior to discharge to assure the patient has a safe discharge plan. **The Attending must see every patient before discharge.**

EVERY PATIENT MUST BE SEEN BY THE ATTENDING PRIOR TO DISCHARGE.
DO NOT DISCHARGE ANY PATIENT UNLESS THIS HAS OCCURRED!
DOCUMENTATION CONSIDERATIONS

- Any admitted patient must have a family history and/or social history documented.
- All patients must have a review of systems documented. Unless you state a complete review of systems was negative, you must document which systems were reviewed. (e.g. 10 of 14 systems were reviewed and negative including Gen, ENT, Eye, Cards, Pulm, Neuro, Skin, MSK, Endo, and Psych)
- Regardless of what a patient is admitted for, they require a complete physical exam. Do not use words such as benign, non-focal, etc..., and deferred. They mean nothing more than you did not do the exam. Admitted patients require at minimum, 9 systems recorded.
- You do not need a complete exam for someone with a minor ailment who is being discharged. In this case a focal exam is acceptable.
- Always document clear vital signs. Do not say “vital signs stable”. It is most appropriate to re-address any abnormal vital signs, particularly if a patient is being discharged. In that case, they should have normalized and you should document to that effect. You can check the nursing notes to verify repeat vitals.
- Please document any consultations to include service, name, times called, whether the patient was seen in the ED, and most importantly the recommendations made. This should occur regardless of whether the recommendations were communicated by phone or by their presence in the ED.
- Please indicate a clear final diagnosis. *Example:* Abdominal Pain, unclear etiology; right ankle sprain; left corneal abrasion, etc. If unsure, ask the attending. This will make billing much easier. Do not use “possible” or “rule out.”
- Always discuss the treatment and follow-up plan with the attending and the patient. Include documentation to this effect. Considering adding “patient understands and agrees with plan” to your documentation.

WORKING WITH OTHERS

- At times, you will be working with senior emergency medicine residents. Part of their training and education is to supervise others. Therefore, it is entirely appropriate to present patients and formulate treatment plans with these residents. Use their knowledge and experience as a resource; ask any questions and brainstorm together. You don’t have to re-present to the attending in these cases, but the attending must see every patient before they leave the ED.
- ED nurses are experienced, skilled, and helpful. Please be respectful of them and treat them as team members. We can’t give our patients good care without them, and they have a lot to teach you.
- Do not delegate care of your patients to medical students. Any patient you see is your responsibility.

FINAL NOTES

Please refer to the associated guidelines meant to assist you.

If you have any questions, please do not hesitate to ask the attending, emergency medicine residents, or nurses. Everyone is here is help you. The more you ask, the more you will learn.

Dress Code: You may wear scrubs but we do not provide them. If you wear scrubs please keep them tucked and professional appearing. Please do not wear a tie as they can be grabbed by patients and are an infectious risk.

Hand Hygiene: Gel in and Gel out of every patient room.

Remove bloody or contaminated gloves before touching anything in the department, i.e. supplies, computers, counters.

Have Fun!!!
Appendix I

LEARNING GOALS AND OBJECTIVES

Patient Care: History Taking
Method: Residency Competency Evaluation Form, Mini-CEX
- Demonstrates the ability to obtain and document an accurate and complete history from patient, caretaker or outside resources with moderate input from faculty
- Specific historical areas include:
  - Symptom driven history for patients presenting with chest pain, delirium, syncope, shortness of breath, weight loss, failure to thrive, infectious syndromes, acute renal failure, edema, trauma, or lacerations.
  - Begin to deal with sensitive topics such as end of life issues and sensitive histories, including sexual history, domestic violence history, psychiatric history, and substance abuse history.

Patient Care: Physical Exam
Method: Residency Competency Evaluation Form, Mini-CEX
Demonstrates the ability to perform accurate and complete physical exam:
- Systematic evaluation for infection or hemodynamic instability
- Cardiac examination for evidence of congestive heart failure including abnormal PMI, JVP, HJR, S3
- Pulmonary exam for evidence of pneumonia or effusion
- Abdominal exam for pain, masses, or organomegaly
- LE exam for evidence of ulcers or orthopedic injuries
- Vascular exam for evidence of venous or arterial insufficiency
- Neurologic exam including mini mental status exam for complaints of weakness, sensory symptoms, and/or altered mental status
- Pelvic exams for women presenting with pelvic or abdominal complaints
Attempts to characterize abnormalities on exam with regular input from faculty.

Patient Care: Medical Decisions
Method: Residency Competency Evaluation Form, Chart Review/Documentation
Reliably recognizes critical illness and appropriately seeks assistance.
Writes progress notes that identify important data and demonstrate thoughtful problem based assessment and plan.
Compares and contrasts the common diagnosis for:
- Pneumonia
- ARF
- Hyponatremia
- Delirium
- Weight loss
- Chest pain
- Abdominal pain
- Hypertensive urgency
- Acute hepatitis and liver failure
Defines, recognizes, and initiates diagnostic and therapeutic management for:
- Non ST segment elevation MIs
- Congestive heart failure
• Common infectious syndromes: community acquired pneumonia, pyelonephritis
• COPD/asthma exacerbations
• Atrial fibrillation with rapid ventricular response
• DVT/PE
• Pancreatitis, cholecystitis, diverticulitis
• Acute renal failure
• Volume depletion
• Delirium
• DKA and NKHOC
• Uncontrolled hypertension

Depends on moderate input from faculty.

**Patient Care: Consultation Process**

*Method: Residency Competency Evaluation Form*

Uses relevant questions to obtain consultation and follow ups on unclear recommendations

**Medical Knowledge**

*Method: Residency Competency Evaluation Form, Attending Review of Written Documentation*

Applies relevant clinical and basic science knowledge in the following common medical conditions:

• Cardiovascular emergencies (chest pain, hypertensive emergency, resuscitation, AAA, congestive heart failure, syncope, shock)
• Respiratory emergencies
• Neurological emergencies
• Infections
• Musculoskeletal
• Toxicology
• Gastrointestinal emergencies
• Endocrine emergencies
• Hyperbaric oxygen therapy
• Hyper- and hypothermia
• Ectopic pregnancy
• PID
• Rhabdomyolysis
• Suicide

**Interpersonal Skills**

*Method: Residency Competency Evaluation Form, Mini-CEX*

Effectively establishes rapport with patients and families

Presents to the attending in an organized and articulate fashion

Appropriately communicates with other health care professionals and consultants

Functions as an effective team member

Provides timely and through electronic documentation of patient care

**Professionalism**

*Method: Residency Competency Evaluation Form, Conference Attendance*
Identifies ethical issues
Strives for patient care and knowledge excellence
Reliably accomplishes assigned tasks
Demonstrates integrity, respect for others, honesty, and compassion
Demonstrates timely completion of administrative tasks and documentation

Practice Based Learning and Improvement
Method: Residency Competency Evaluation Form
Identifies ethical issues and solves them using available resources
Provides counseling on professionalism for more junior team members
Sets a tone of respect and collegiality for the team and acts as a role model for patient care and professional behavior

Systems Based Practice
Method: Residency Competency Evaluation Form, 360 degree evaluation
Effectively communicates with nurses and other professionals to optimize patient care
Writes effective notes
 Appropriately transitions patients to the next level of care, discharge planning, and hospitalization
Uses strategies to obtain information from other practitioners about patients’ current health
Reflects on healthcare provided and has awareness of cost effective practices