UNC School of Medicine
Department of Emergency Medicine
Medical Student Clerkship in Emergency Medicine
2014-2015

Course Director: Jonathan Jones, MD
Education Chief Residents: Alyssa Ratzlaff, MD; Genevieve Schult, MD
Medical Student Education Coordinator: Kari Corker
Emergency Medicine Clerkship Rotation Important Contacts

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Jim Barrick
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Student Affairs:
Leanne Shook
leanne@med.unc.edu or 962-8338
Introduction

Welcome to the Emergency Department at UNC and at Wake Medical Center! We are excited to have you spend a month with us, and hope that many of you will love EM as much as we do. Our goal is that you will learn valuable skills to enhance your knowledge base and that you will recommend this elective to your friends in the upcoming years as a valuable learning opportunity.

We have made several structural changes to the clerkship this year which will give you a more well-rounded experience with more simulation time, increased emphasis on procedures and ultrasound, and improved interactions with residents, attending and staff in our department. We recognize that your time is valuable, and despite the various requirements for completion of this rotation, you may find that you have more time than you realize and we hope that you will make the most out of your clerkship with us.

There are many opportunities for feedback of your faculty, the simulation sessions, the residents and the clerkship overall. We welcome and look forward to having your input, as this does affect change and improves the rotation for your colleagues. Please feel free to be open with your comments.

If at any time you are unable to reach the course director, or clinical coordinator at Wake Med or at UNC, feel free to e-mail Education Director Residents, Alyssa Ratzlaff or Genevieve Schult, for additional assistance.

We hope you have an outstanding experience with us this month!

Jonathan Jones, MD, FACEP  
Medical Student Clerkship Director

Alyssa Ratzlaff, MD
Genevieve Schult, MD
UNC EM Educational Director Residents

Kari Corker  
Medical Student Education Coordinator
Requirements for Successful Completion of EM 401/SURS 402

1. **Completion of the EPIC training:**
   Currently in process; check with your attending at beginning of the shift.

2. **Clinical Experiences in the Emergency Department:**
   Each student on the Emergency Medicine rotation will be assigned 7 shifts at UNC and 6 shifts at Wake Medical Center Emergency Medicine Departments (13 shifts total, 2 weeks at UNC, 2 weeks at Wake Med). Sometimes the number of shifts at UNC and WakeMed will change but you will always have a total of 13. Critical Care students will also be assigned all 13 shifts at UNC and WakeMed. An important component of professionalism is accountability and reliability. **Students are expected to know when and where their shifts are scheduled and to be on time.**

   Any Absence must be reported to the Student Coordinator, 966-6442/ 843-8067 as well as the assigned ED attending at 966-4721. Dr. Jones will be notified. For absences from Wake Med call 919-350-7873, ask for Nicole Proctor.

   **Anticipated absences including interviews and medical school functions MUST be reported as far in advance as possible and shifts rescheduled. Only 2 shift changes are allowed per student during the month. No guarantees for changes of shifts except for residency interviews.

   **Absences due to illness will be rescheduled at the convenience of the course director.**

3. **Other Educational Experiences:**
   - **Emergency Medicine Conference:** Conferences for the department of emergency medicine are held on Wednesday mornings from 7AM to 12PM in the physician’s office building, 1st floor, room 1101. The first conference of the month is held at Wake Med. Your conference schedule will be e-mailed to you or given to you at the orientation meeting. Be sure to check your e-mail the evening before conference to check to see if there are any changes and you are not required to attend. To ensure you receive credit for attending conferences, make sure you sign the rosters that are passed around. If you do not sign the attendance sheet we will assume you were absent and make up work will be expected.

   - **Emergency Medicine Simulation Sessions:** A unique clinical simulation educational experience will be held once monthly. These simulations will cover an Emergency Medicine basic curriculum with an emphasis on acute clinical presentations and management; they are administered by the junior and senior residents as well as Dr. Jonathan Jones.

   - **Objective/Procedure Cards:** Part of ensuring that your experience in the emergency department is comprehensive across the curriculum, we have designed an objective and procedure card that you can carry with you in your pocket. It will also contribute to a portion of your grade and it is required that you have **80% completion of the card to receive credit as well as 100% of the required procedures (cardiac monitors, IV’s, blood draws, EKG).** The required number of procedures is indicated on the card. For example, IV’s- 4 minimum is listed as “4 min” (you will need to be signed off on starting at least 4 IV’s). You are encouraged to exceed this number of procedures during your rotation.
The objective/procedure card is meant to ensure that we are teaching you and guaranteeing a well-rounded experience in the department. It is important for you to be proactive in order to complete as many procedures as possible. The ED is a perfect environment to practice your clinical skills such as: IV placement, blood draws, obtaining an EKG, applying oxygen or a nebulizer treatment, etc, etc. Take advantage of this rotation. Remember that intern year is just around the corner!!! Procedures and Discussion topics may be signed off by a resident, nurse or attending who acted as a preceptor you. Your card must be turned in at the end of your clerkship.

- **Weekly Reading Schedule:** You will be given a weekly reading schedule for review of essential “bread and butter” emergency medicine topics. These reading topics should reinforce and add to the clinical cases you see in simulation as well as help you to appropriately manage patients in the ED. You can read at your own pace, as long as reading is completed by the end of your month. Keep in mind that end of rotation test questions will be largely based on information found in the reading. We recommend that you read in your Tintinalli Handbook on the subjects covered in the discussion/procedure card and on the diseases and injuries that you encounter with your patients. There is a link to further readings on the “Current Rotating medical students” page of the UNC EM website. The Rosh EM Pre-Test Book that is provided to you for the rotation has 500 USMLE style EM questions with answers for you to practice.

- **Journal Club:** Journal Club will be held once on a Tuesday night during your block or during one of the Wednesday residency conferences. You are invited and expected to attend. JC consist of an informal discussion of several journal articles over dinner. We will send you the information about the articles once they are available each month. If you are working a shift during JC, you are excused for the time period you attend JC.

**ALL STUDENTS MUST ATTEND ALL LECTURES AND OTHER REQUIRED ACTIVITIES. ATTENDANCE WILL BE TAKEN AS DOCUMENTATION FOR YOUR GRADE**

5. **End Of Clerkship Exam:**
This will be an online exam given the last day of the clerkship and will be in the AIMS format that you used during your first and second years. You will log on through the Internet browser on the last day of your block at 9am in the Physician’s Office Building, Room 1125. It will be multiple choice and is 60 questions. The test will count towards 25% of your grade. To review the Orientation to take home on-line exams you can go to www.med.unc.edu, → 4th year student resources → laptop FAQ’s → preparing your laptop for online testing. You should be able to take the test from any online (not wireless internet) computer.

**Recommended study materials for final exam:**


Through the Health Affairs Library site you may access- Access EM. Here you will find over 800 question and answers relating to emergency medicine.
**GRADES**

- **Faculty rotation evaluations (45%)**
  - Patient Care: Delivery of care that is compassionate, appropriate, and effective
  - Medical Knowledge: Basic fund of knowledge and the application to patient care
  - Practice-Based Learning and Improvement: The ongoing appraisal and assimilation of scientific evidence, and improvement of patient care
  - Interpersonal and Communication Skills: Effective information exchange with patients, their families, and other health professionals
  - Professionalism: Manifested as a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population
  - Systems-Based Practice: Demonstration of an awareness of the larger context and system of health care and the ability to effectively call on system resources to provide care.

- **End of rotation computer test (25%)**

- **Professionalism (20%)**
  - Resident and student lectures attendance
  - Being on time for shifts
  - Demonstrated work ethic during rotation
  - Interaction with office staff, nurses, residents, and attendings
  - Turning in Tintinalli book and Rosh book (within 3 days of end of rotation).

- **Rotation card (10%)**
  - 80% completion is required for credit as well as 100% of required procedures. You can find the required procedures listed on the actual rotation card.

**Grade Breakdown**
Honors- 93-100 (need 85% on final exam to be considered)
High Pass- 80-92
Pass- 70-79
Fail- < 70

**Students interested in EM as a career choice will need to meet with UNC EM program director Dr. Kevin Biese for a 30-minute session, and should also make an appointment to meet with Dr. Jonathan Jones. Sessions must be scheduled in advance by e-mail or via the student coordinator.**

**Please see and SIGN the forms at the end of this packet for a further explanation regarding your grade calculations**
IMPORTANT ITEMS TO KEEP IN MIND:

1. Check in with ED Attending 10 minutes before the beginning of your shift and introduce yourself. You are assigned to either A or B side depending on your specific shift. Note that your shift is 1 hour longer than the attending. This hour is built in for charting and to tie up loose ends. Do not see any new patients during this last hour of work.
   a. A side: 7 am - 4 pm, 3 pm - 12 am, 11 pm - 8 am
   b. B side: 10 am - 7 pm, 6 pm - 3 am

2. All patients who are seen in the Emergency Department are the responsibility of the attending emergency physician. Consequently, **YOU MUST PRESENT EACH PATIENT TO THE ED ATTENDING IMMEDIATELY AFTER YOUR EVALUATION.** Only the ED attending can sign your orders to get the work-up started. Present early and avoid significant delays in patient care. Notify your attending immediately if you suspect that your patient is unstable in any way.

3. THE ED ATTENDING MUST SEE EVERY PATIENT PRIOR TO THE PATIENT’S DISCHARGE, ADMISSION, OR TRANSFER.

4. Although you will be quite busy at times, make sure you speak to any family after you have finished your evaluation. It is important to let them know how well the patient is doing and give them an estimate of the anticipated length of stay. Always overestimate the length of stay. Things take longer than you think.

5. Laboratory studies and X-rays are ordered only if they impact on acute treatment, immediate decision making, or are essential for the provision of follow-up care. The Emergency Department is not the place to begin an extensive workup of non-critical problems.

6. Every patient should be given instructions for follow-up care and referred to a follow-up physician, no matter how trivial the problem may seem. (See documentation and charting guidelines)

7. You should be able to arrive at a reasonable clinical diagnosis on most patients. If you lack a definitive diagnosis, you must have formulated a clear differential diagnosis and have ruled-out all possible life-threatening conditions before the patient can be discharged safely.

8. Information concerning patients seen or discussed in the ED is **confidential.** It should not be discussed anywhere, except during a medical conference setting. You must not discuss patient information in public settings.

9. Some patients have a serious illness at the time of presentation and they may decompensate quickly. In these circumstances it is vital for you to notify the attending physician of the patient’s condition **IMMEDIATELY and possibly before you have finished your initial evaluation.** A partial list of these conditions is attached in this handout, but uses your clinical judgment. **If you think a particular patient is unstable, alert the attending on duty.**
10. As patients enter the Emergency Department, they are triaged by the nursing staff. **Triage designations are:**

<table>
<thead>
<tr>
<th></th>
<th>ESI-1</th>
<th>ESI-2</th>
<th>ESI-3</th>
<th>ESI-4</th>
<th>ESI-5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stability of vital functions</strong></td>
<td>Unstable</td>
<td>Stable</td>
<td>Stable</td>
<td>Stable</td>
<td>Stable</td>
</tr>
<tr>
<td><strong>Life-threat or organ-threat</strong></td>
<td>Obvious</td>
<td>Reasonably likely</td>
<td>Unlikely (possible)</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Severe pain or severe distress</strong></td>
<td>Immediately</td>
<td>Sometimes</td>
<td>Seldom</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Expected resource intensity</strong></td>
<td>Maximum: staff at bedside continuously; mobilization of outside resources</td>
<td>High: multiple, often complex diagnostic studies; frequent consultation; continuous (remote) monitoring</td>
<td>Medium: multiple diagnostic studies; or brief observation; or complex procedure</td>
<td>Low: one simple diagnostic study; or simple procedure</td>
<td>Low: exam only</td>
</tr>
<tr>
<td><strong>Med/staff response</strong></td>
<td>Immediate team effort</td>
<td>Minutes</td>
<td>Up to 1 hr</td>
<td>Could be delayed</td>
<td>Could be delayed</td>
</tr>
<tr>
<td><strong>Expected time to disposition</strong></td>
<td>1.5 hr</td>
<td>4 hr</td>
<td>6 hr</td>
<td>2 hr</td>
<td>1 hr</td>
</tr>
<tr>
<td><strong>Examples</strong></td>
<td>Cardiac arrest, intubated/hypotensive trauma patient, acute (&lt;3 hr) MI or stroke</td>
<td>Most chest pain, stable trauma (MOI concerning), elderly pneumonia patient, altered mental status, behavioral disturbance</td>
<td>Most abdominal pain, dehydration, esophageal food impaction, hip fracture</td>
<td>Closed extremity trauma, simple lac, simple cystitis, typical migraine</td>
<td>Sore throat, minor burn, recheck</td>
</tr>
</tbody>
</table>

These designations are listed next to the patient’s name on the T system board. Patients triaged as “1” or “2” should be evaluated before those designated “3-4-5.” **Medical students are not to evaluate patients triaged “1” without direct supervision by the ED attending or an upper-level resident.** If you are unsure which patient you should evaluate next, ask the attending or a senior resident to direct you. **Medical students should check with attending before going to see a level “2” patient.**

**ROLES AND RESPONSIBILITIES:**

**Role of the Emergency Department Attending:**
- Responsible for patient flow and consultation.
- Responsible for the supervision of all medical students and residents.
  - **Note:** Residents cannot sign student orders.

**Role of the PGY-III Resident:**
- Directly evaluate patients as the primary physician, with particular attention to critically ill or injured patients.
- Ensure that patient flow in the ED is maintained.
- Supervise one or more PGY-I residents who are working in the ED.
- Perform or supervise procedures required for patient care.
Role of the PGY-I and PGY-II Residents and Medical Students:
- Responsible for direct patient evaluation and management.
- Present patients directly to attending physicians

PATIENT CARE AND CASE PRESENTATION:
Patients are to be seen according to their time of entry into the ED unless another patient with a potentially life-threatening complaint has not yet been evaluated. Patients with life-threatening complaints are designated by a triage classification of “1” (in red) medical students are not to evaluate patients triaged “1” without direct supervision by the ED attending. Students are encouraged to participate in the resuscitations of Triage 1 patients as a team member under the supervision of the attending.
If you are not certain whether a particular patient is to be seen, ask the attending physician or triage nurse.

ANY PATIENT WITH A CONDITION THAT MAY DETERIORATE PRECIPITOUSLY MUST BE CALLED TO THE ATTENTION OF THE ED ATTENDING IMMEDIATELY, EVEN IF THE INITIAL EVALUATION IS NOT COMPLETED.

- The initial evaluation must include a history and physical examination. The exam may be “directed” if the patient has an obvious isolated problem. Otherwise patients should have a complete history and physical examination including social and family history, medications, and allergies. This evaluation should take no longer than 5 to 10 minutes to complete.

- Students are to present the patient to the ED attending after formulating a differential diagnosis and treatment plan, but before writing orders. The ED attending must countersign all orders written by students. **Verbal orders are NOT acceptable.**

- After completion of the ancillary studies; the student should present the case to the ED attending again to discuss the results and make the disposition. A disposition or consultation will be made and the patient will be discharged, admitted, or transferred to a different institution.

TYPES OF PATIENTS SEEN:
- **General medical and surgical processes** - These will be the most common type of patients you will see in the ED.

- **Psychiatric** - Our responsibility is medical clearance. Be especially careful with elderly patients or those with confounding medical problems.

- **OB-GYN** - Women at 20 weeks or greater gestation are transferred directly to Labor and Delivery. The exceptions to this are if she has sustained trauma or if she has a complaint unrelated to pregnancy. All women between 10-60 years old should be assumed to be pregnant until proven otherwise by a negative urine pregnancy test.

- **Trauma** - Pre-established criteria determines who is responsible for the management of RED Trauma i.e. the Trauma team vs. the Senior Emergency Medicine Residents. Patients triaged as YELLOW trauma are evaluated and treated by the general ED staff.
• **Pediatrics** - (ages 15 and below) Seen directly by a Pediatric resident, either in Pediatric Acute Care (9AM-11PM) or in the Acute Care ED at other times.

**ANCILLARY SERVICES:**

• **Laboratory Studies**
  - Ordered in writing on the order sheet. **Be specific**, the ordering of panels is not permitted.
  - Results can be viewed on the computer in WEBCIS or on the clipboard as a hard copy. Be sure to check the computer frequently for results so the patient can receive disposition in a timely manner.
  - **All laboratory studies must be documented on the patient’s T-system chart**, including those that are pending at the time of disposition.

• **Radiological Studies**
  - X-ray orders should be written along with a reason for the X-ray study (i.e. chest pain, knee pain). The X-ray orders are entered into the computer by the HUC. After 5PM and weekends, special studies such as extremity dopplers and V/Q scans require the ordering physician to call the radiology resident to arrange the test.
  - Look at the patient’s X-rays on the PACs system even though the radiologist’s interpretation is dictated into Webcis. Remember that you have the advantage of knowing the patient’s clinical presentation and thus may notice something the radiologist might have missed.
  - If you have any questions regarding the interpretation of a particular radiograph, you may consult the ED attending, or the radiology resident, whose name and beeper number are posted in the X-ray reading room.
  - **All radiology and Lab studies must be documented on the patient’s T-system chart!**

**CONSULTATIONS:**

• Consultation for admission to the Internal Medicine or Family Medicine services should be directed to the appropriate team for admission. It is imperative that you determine if the patient is followed by UNC Internal Medicine or UNC Family Medicine by looking at the Family Medicine admit list at the A and B side desks. If the patient is followed by Family Medicine, he will be admitted to that service. Before seeking consultation from other services, you must discuss the case and the need for the consult with the attending.

**PATIENTS LEAVING THE EMERGENCY DEPARTMENT AGAINST MEDICAL ADVICE (AMA):**

• All patients who threaten to leave the Emergency Department against medical advice (AMA) must be seen by the ED attending **immediately**. The patient is required to sign an AMA form and must be informed of the risks of leaving.
SCHEDULE:
• Students will be assigned to one section of the department and will report ONLY to the attending staffing that section. The attending for your shift will have the same time schedule as you. This attending will see and manage all patients with you during your shift. Changes in the schedule cannot be made without the approval of Dr. Jones. To make changes contact Jennifer Link at 966-6440.

SECURITY AND PARKING:
• Escorts to the parking decks are available 24 hours a day. USE THEM!! Use the Point-to-Point Service (962-7867) or have hospital security accompany you. You are not permitted to park in the ED patient parking lot.

DRESS CODE AND IDENTIFICATION:
• Name badges must be worn at all times.
• Scrubs are acceptable for wear in the Emergency Department provided they are clean and in good condition. Jeans, shorts, sweats and T-shirts are not permitted.

Morning ROUNDS:
• At 7 am sharp, “rounds” are held at the A-side attending desk. Be on time! All interns, residents, students, and attendings working on the previous night shift briefly present their patient’s medical condition and the status of their evaluation. Students are expected to present their own patients.

WHEN YOUR SHIFT ENDS:
• You MUST turn your patients over to the attending or senior resident.
• If the evaluation is in progress, please have a clear plan to pass on to the next doctor. The best policy is to schedule your evaluation so that it is complete at the time of shift change.
• ALWAYS LET THE ATTENDING KNOW WHEN YOU ARE LEAVING

Documentation Standards
The following information is required on all charts for all Emergency Department patients for legal and billing purposes. Please review this in conjunction with the copy of the chart included in this packet.

• Always include the vitals signs in the physical exam section of the chart. You must copy and paste them from the nursing chart.

• Document the time you initially saw the patient for every chart.

• Use history/present illness section to include information on the Past Medical History (PMH), Social History (SH) and Family History (FH). Sometimes you may only document “noncontributory”. Important and pertinent social history in the ED settings includes uses of tobacco or alcohol, and with whom the patient lives.

• You need to list all the medications the patient is taking and any drug allergies. Document “none” if these are negative. Do not leave this section blank.
The history of the present illness and physical exam should be limited to what is pertinent to the patient’s main complaint.

All laboratory studies, EKG, and X-rays are recorded in the T-system chart.

Fill in the review of systems as pertinent to the patient. If you have described this in the HPI, note that. **Complex patients (any patient ill enough to be admitted) require 10 different ROS.** Make sure you circle the “otherwise negative” option.

Fill in the Physical Examination. For complex or critically ill patients you have to be complete. **All patients are required to have 8 body systems examined.**

After you record the history and physical, write a short assessment including differential diagnosis. Alternately, you can make a problem list of the patient’s acute problems. In the differential diagnosis, include what you believe are the patient’s problems, as well as other alternative diagnoses. You can free text in the progress note section of the T-system chart.

Based on the differential problem list that you have established, it should be obvious by reviewing the chart how you distinguished among the possibilities and came to your final diagnosis. This section is very important for outside observers to clearly understand your thought process in evaluating the patient.

If you make a clinical diagnosis without a significant work-up, you need to explain what in the history and physical led you to avoid additional testing.

If the patient is in the ED for a significant length of time, you need to make note that you re-evaluated the patient during this time. Many conditions such as respiratory distress, chest pain, and abdominal pain require frequent re-evaluation, and you need to document your findings in the progress section of this chart.

If you counseled the patient about a health problem (i.e. diet, importance of taking HTN meds, need to drink less ETOH), type this in the chart in the progress note section. All patients evaluated for STD’s must be counseled about HIV, and you must documents this conversation.

If you call a consultant to see the patient, write down the time that you called and the consultant’s name in the progress note section. “Curbside” consultations are not official. The patient must be seen by the consultant.

Write a procedure note for all procedures done on the patient. Common procedures include lumbar punctures, suturing, and central lines. Obtain consent when appropriate, and discuss the details with the attending.

- For lacerations, you need to include the following information:
  - Location on body.
  - Size in cm and shape of wound.
  - Clean or contaminated.
  - Describe the repair: Irrigation, type of suture, number of sutures.
• Remember to document tetanus status for all wounds.

• Diagnosis – Completed on the last page of your T-system chart. The primary diagnosis pertains to why the patient is in the ED. If the patient has an underlying disease that is pertinent, (HTN, DM, CAD), these are secondary diagnoses.

• Condition on Discharge - Statements such as “Good” or “Improved” are best. “Stable” is also acceptable. The patient should usually be admitted if the condition is “poor,” “serious,” or “critical.”

• You will need to lock all your charts before leaving at the end of your shifts. Be sure to review the chart first to be sure it is complete. All patients should have a “level 5” code.

DISCHARGE INSTRUCTIONS:
• These are very important and a common source of legal problems in Emergency Medicine – so take the time to do it thoroughly.

• Instructions are generated from the final page of your T-system chart.

• They can be printed in Spanish if needed.

• You must include in your instructions:
  o Medications: List any new medications you have prescribed for the patient including purpose, dose, route, and frequency. If you select the medication from the T-system chart list, instructions will be included for the patient.
  o Diagnosis: Do not guess. If you are unsure, choose “abdominal pain of unknown origin” or “chest pain of unclear etiology”.
  o Reasons to return: What exactly to return to the ED for (temp >101.5 despite Tylenol, unable to keep fluids down, increased pain). You need to be specific. The patients are often medically unsophisticated and might not know when something is wrong. DO NOT USE MEDICAL TERMS!
  o Follow up plans: Specific plan for follow up: who to call, phone numbers, when to call, and what to be seen for. Every patient, even those with the most minor complaints, should be given some follow up instructions. If the patient is given a phone number for a new appointment, fill out the referral form and hand to HUC to fax to the clinic. Some patients are simply told to come back to ED for a recheck. Be specific when you want the patient to return.

• The resident or student should verbally review the discharge instructions with the patient and/or family.
The following is a list of conditions that require immediate notification of the Emergency Department attending physician, regardless of your level of training. This list does not cover all possible situations, and you should notify the attending immediately if you have a patient you feel may deteriorate precipitously or if you are uncomfortable given your present level of training.

- Any patient who presents with or develops acute cardiopulmonary arrest.
- Any patient with a complete or partially obstructed airway.
- Any patient who presents with a significant cardiac arrhythmia.
  - Including heart rate greater than 150 or less than 60 beats per minute
- Any patient with acute altered mental status.
- Any patient with acute stroke like symptoms.
- Any patient with significant hypotension or hypertension.
  - Significant hypotension is defined as blood pressure of less than 100 mmHg systolic.
  - Significant hypertension is defined as a blood pressure of greater than or equal to 180 mmHg or hypertension associated with acute alteration of mental status.
- Any patient with severe respiratory distress.
  - A respiratory rate greater than 30 breaths/minute,
  - Any patient with a pulse oximeter reading of less than or equal to 90 mmHg,
  - Any patient with an acute elevation of pCO2 greater than or equal to 60 mm Hg,
  - Any patient with a complaint of shortness of breath accompanied by diaphoresis,
  - Use of accessory muscles of respiration,
  - Cyanosis,
- Any patient with evidence of acute myocardial infarction.
- Any patient with a fever greater than 105 degrees Fahrenheit, any patient with significant alteration of mental status associated with a fever, or any patient with a fever and a potentially immunocompromised state (e.g. HIV disease, cancer patients, transplant patients, etc.)
- Any patient with significant hypothermia. For these purposes, significant hypothermia is defined as a rectal temperature less than or equal to 95 degrees Fahrenheit.
- Any patient with severe abdominal pain or abdominal pain associated with peritoneal signs.
- Any patient with significant upper or lower GI bleeding.
- Any female with abdominal pain and a positive pregnancy test.
- Any patient with a pregnancy and sign/symptoms of a precipitous delivery.
- Any patient who develops seizure activity while in the Emergency Department.
- Any patient with significant abnormality of any laboratory value (e.g. hypo/hypernatremia, hypo/hyperkalemia, symptomatic hypercalcemia, hematocrit less than 28).
- Any patient with a history of significant trauma.
- Any patient with an overdose of prescription or over-the-counter medications.
- Any patient who gives evidence of becoming significantly agitated, violent, or suicidal.
- Any patient with a blood sugar of less than 70 mg/dL.
- Any patient with a snake bite.
- Any patient with significant bleeding, or bleeding associated with hemophilia.
- Any patient with a significant allergic reaction.
- Any patient who you feel is beyond your present capabilities or whom you think may deteriorate.
Welcome! From the Nurses in the Emergency Department

- The ED is divided into several sections:
  - Triage
  - Acute Area (A and B sides)
  - Fast Track
  - Pediatric Acute Care

- The nursing staff is assigned by “team.” One or two nurses are assigned to the triage area. These nurses are responsible for screening all patients and prioritizing their care. The Acute Area is divided into Team A and Team B. Two or more nurses are assigned to cover each of these teams.

- There are three trauma bays, including a pediatric resuscitation bay. There are two cardiac resuscitation rooms. The Team A consists of beds 1 through 14, and beds 32 through 37. Team B consists of beds 15 through 31. A nurse is assigned to cover Fast Track during its hours of operation 9 am to midnight. An assigned intern or resident staffs Fast Track.

- There is a pediatric float nurse on evening shift and a nurse assigned only to the pediatric acute care area. Residents from the Department of Pediatrics staff the pediatric area.

- A charge nurse is assigned to coordinate the care of the ED patients. At various times, the charge nurse will also have a patient care assignment. Two nurses are assigned to the trauma team. If there is a trauma in progress and the nurse assigned to a certain area becomes unavailable, refer all questions to the charge nurse.

- Remember, if you are busy, so is the nursing staff! This is a team-oriented department.

General Information

- It is mandatory that you wear your nametag!

- Familiarize yourself with the clean and dirty utility rooms on your first day. You will find this very useful. Most of the equipment you need is located in these areas. Equipment is secured in the PYXIS, and nurses have access to these machines.

- Tidy up after yourself after completing an exam or procedure. There are trash cans located at each patient care bedside. Try to leave the room as you found it.

- The clerk (HUC) can help you with phone calls and paging. Clerks answer the phones, even if you have paged someone. Listen to the intercom for your name or the person you have paged.

- Nursing Assistants (NA) can perform simple wound preps, crutch set-up, patient transport, room set-up, and assistance with procedures

- Remove all needles and sharps from trays and dispose of them in the sharps box!

- Unless the patient is acutely ill, please allow the RN to triage the patient prior to beginning your exam or gathering information.
EM Clerkship
Medical Student Grade Determination

(Your composite grade will be determined by the following calculations)

Faculty evaluations (45%)
- Each Monday morning of the rotation, please send Kari Corker an e-mail (Kari_Corker@med.unc.edu) with the list of attendings you worked with during the previous week.

Computer based test (25%)
- You must receive at least an 85 on the exam to receive an honors for the course.

Professionalism (20%)
- Resident lectures and simulation attendance
- Being on time for shifts
- Demonstrated work ethic during rotation
- Interaction with office staff, nurses, residents, and attendings
- Turning in Tintinalli book and Rosh Pre-Test book (within 3 days of end of rotation)

Rotation card (10%)
- 80% completion is required for credit as well as 100% of required procedures. You can find the required procedures listed on the actual rotation card.

In signing this Grade Determination I confirm that I understand the requirements and determinants of my grade for this clerkship. I also pledge that I have neither given, nor received aid on any part of the testing aspects of this clerkship, in keeping with the UNC Honor Code.

Signature required: ________________________________________________________________
Medical Student End of Clerkship
Check off List
(To be signed and taken up when the students turn in their packets. You will not receive a grade until all materials all turned in.)

Name (student): _________________________________

Items to be turned in:

• Discussion Card
  ○ Discussion & Procedures

• Tintinalli Book

• Rosh Book

• Evaluations
  ○ Clerkship
  ○ Faculty